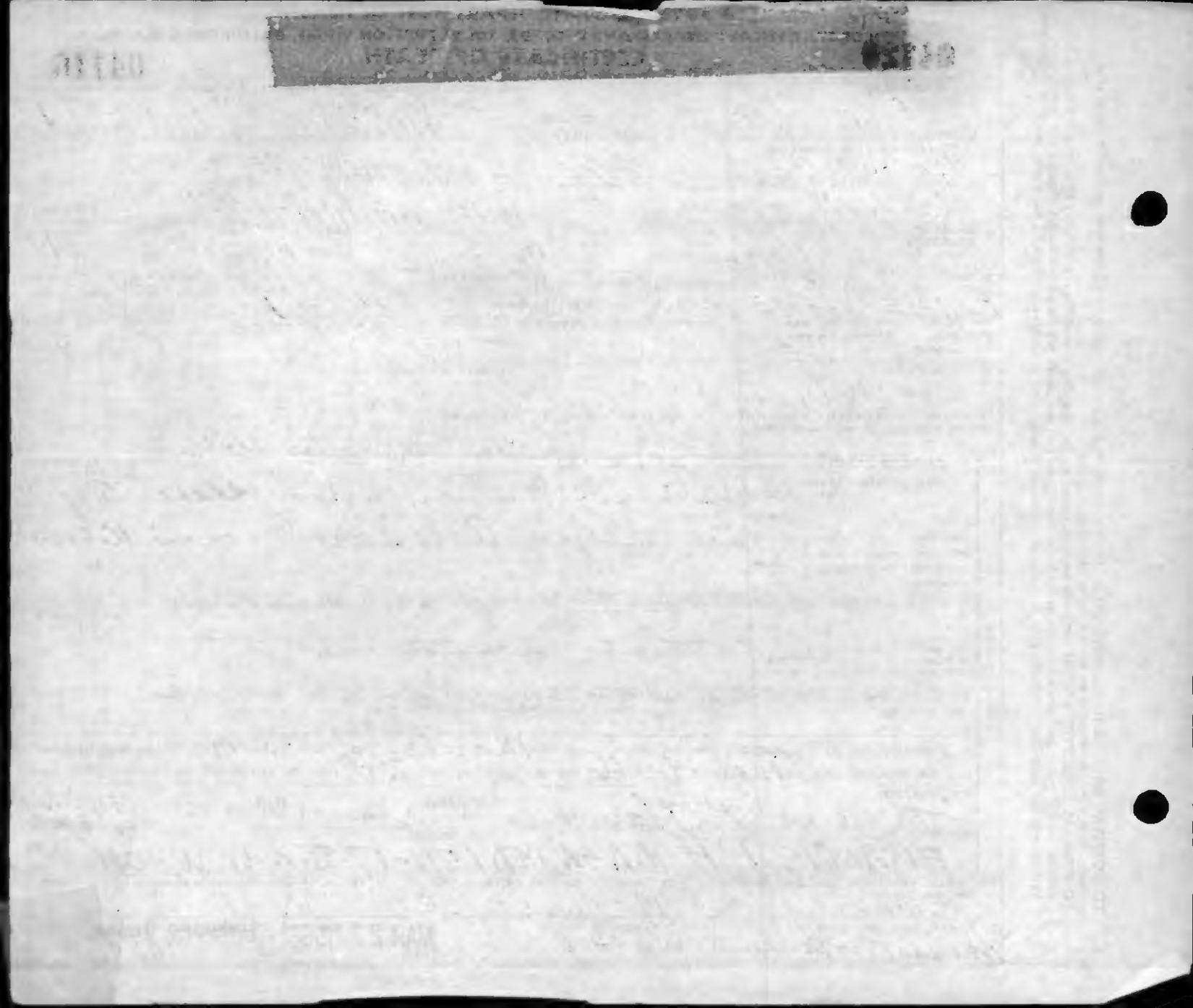


**TO HOSPITAL OR ATTENDING PHYSICIAN:** This requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove the seal paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04116  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<b>PRINCE GEORGE MARYLAND</b>		a. STATE <b>MARYLAND</b>	b. COUNTY <b>PRINCE GEORGE</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<b>HYATTSVILLE</b>		<b>6 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<b>CARROLL MANOR</b>		<b>HYATTSVILLE Washington</b>	
f. STREET ADDRESS <b>1006 - 10th St. N.E.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		h. DATE OF DEATH <b>MAR. 19. 1966</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH MONTH DAY YEAR	
<b>NORA</b>		<b>MAR. 19. 1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>APR. 5 1874</b>	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>92 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<b>Housewife</b>		<b>IRELAND.</b>	
11. BIRTHPLACE (Country & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
<b>IRELAND.</b>			
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>CARROLL MANOR Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		<b>Arteriosclerotic Heart Disease 5 yrs.</b>	
		<b>Generalized Arteriosclerosis 10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 15, 1966</b> to <b>Mar. 19, 1966</b> that (I) (we) last saw the deceased alive on <b>Mar. 19, 1966</b> and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>3/19/66</b>	
22a. SIGNATURE <b>Francis P. Hannan, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>FRANCIS P. HANNAN, M.D.</b>		22d. ADDRESS <b>1511-17 ST. N.W. WASH. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/23/1966</b>	
		23c. NAME OF CEMETERY OR CREMATORIAL <b>MT. OLIVET CEM.</b>	
23d. LOCATION (City, town or county) <b>WASH. D.C.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas B. Hanlon - WASH. D.C.</b>		ADDRESS	
		25a. REGD. BY REGISTRAR DATE <b>MAR 29 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>francis p. hanlon</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

04122

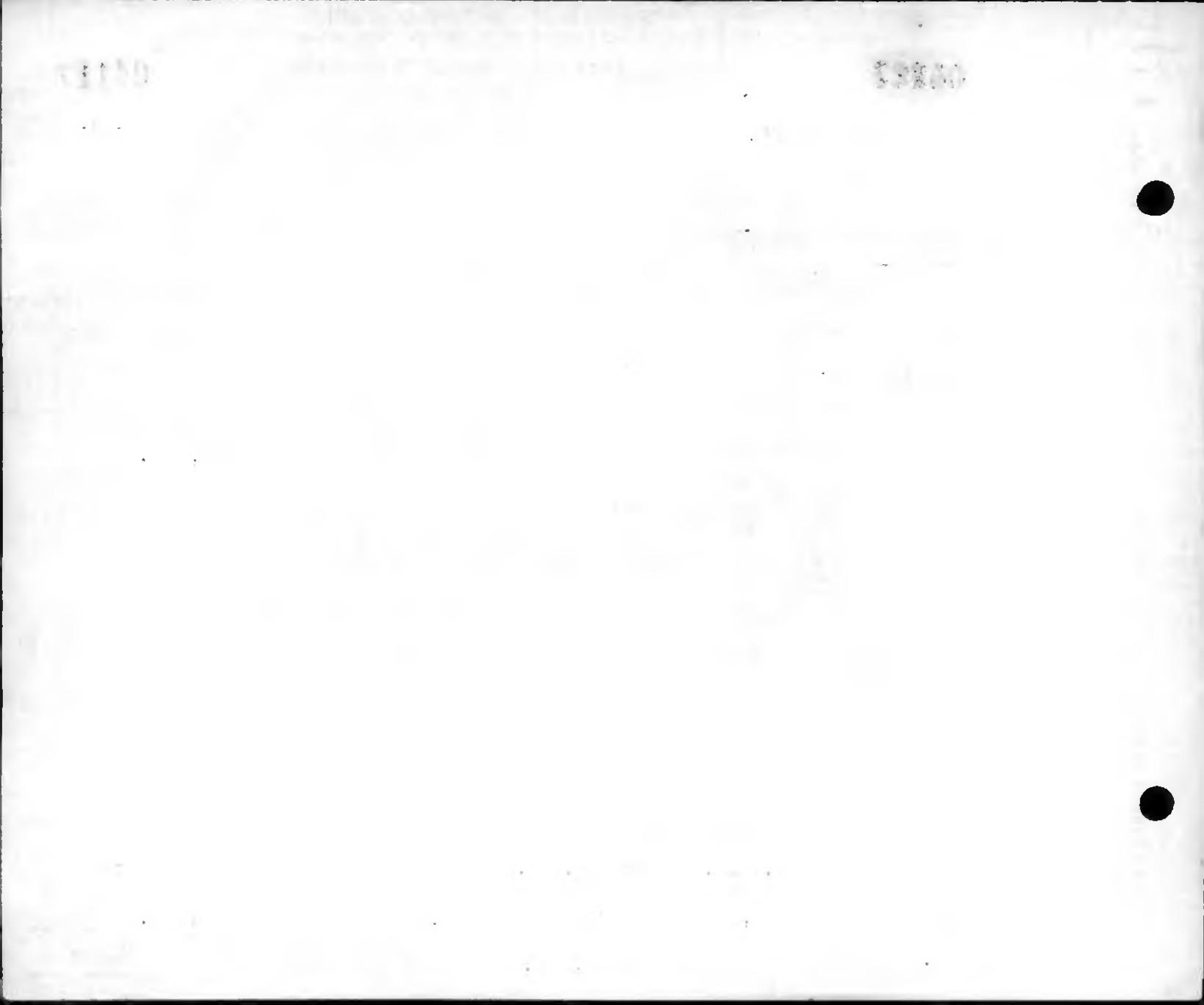
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04117

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>4608 Emerson Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Thomas Eldridge Arnold</b>		First	Middle	Last	4. DATE OF DEATH <b>3</b>	Month	Day	Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 May 1889</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Section foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Carroll Arnold</b>		Address <b>Landover, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>4200</b> { b) <b>Arteriosclerotic heart disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes <b>over 5 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		<i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>3-30-66</b>	
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 1, 1966</b>		23c. NAME OF CEMETERY OR BURIAL <b>George Washington</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattsville, Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~move~~ give nearest town, write RURAL and give nearest town, write RURAL and give nearest town, Within 72 hours after death.

M

04128

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04118

Item 23a Film 6375 4/4/66 m.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>25 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4907 42nd Avenue</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Herbert</b>	Middle <b>F.</b>	Last <b>Audas</b>	
4. DATE OF DEATH Month Day Year <b>March 25 1966</b>	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11/7/98</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Division chief U S Government</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Madison New York</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Edward N Audas</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth De Laney</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	16. SOCIAL SECURITY NO. <b>W</b>	17. INFORMANT <b>Catherine P Audas</b>	Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
Cate Cadre Failure Cate is older Heart Disease				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
19				
21. I certify that (I) (this hospital) attended the deceased from <b>8-1</b> , 19 <b>55</b> to <b>5-22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-22</b> 19 <b>66</b> , and that death occurred at <b>2:30</b> M, from the causes and on the date stated above.				
22a. SIGNATURE <i>C. Deitz</i>	22b. DATE SIGNED <b>am March 25, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. Deitz</b>	22d. ADDRESS <b>Brooks Plaza - Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar 28, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Crematory</b>	23d. LOCATION (city, town or county) <b>Colmar Manor, Md.</b>	(State)
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

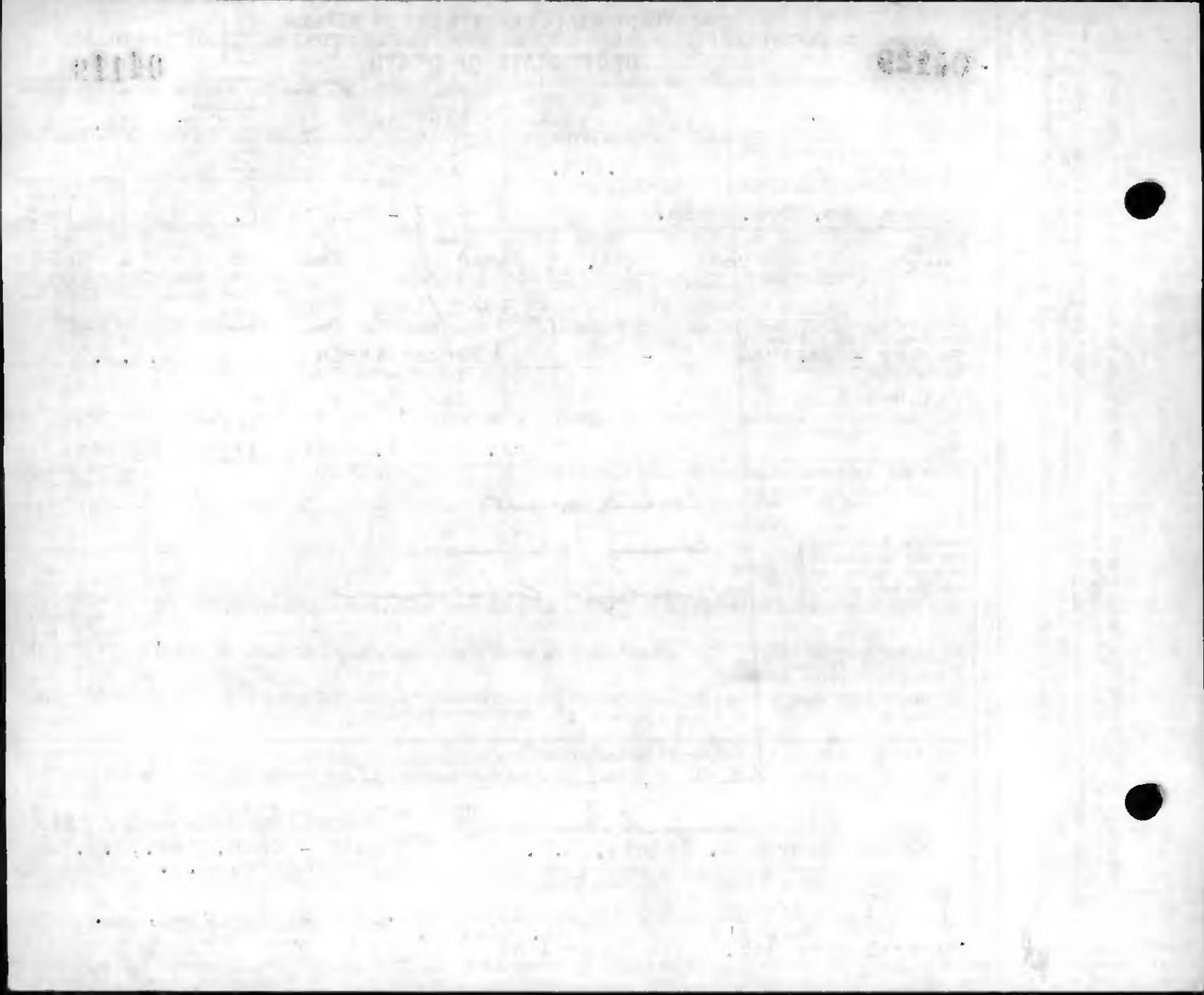
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial/cremation, or removal, and in event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04129		04119	
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Geo. Gen. Hosp.</b>		d. STREET ADDRESS <b>9127 - Alcona St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Fred</b>	Middle <b>A.</b>	Last <b>Awad</b> 4. DATE OF DEATH Month <b>3</b> Day <b>1</b> Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/22/1905</b> 9. AGE (in years last birthday) <b>60</b> yrs. 10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. 11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Albert Awad</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rokus</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Mary A. Fratta (above address)</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>coronary arrest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Daughter</b>	
(b) DUE TO <b>coronary occlusion</b>			
(c) DUE TO <b>Generalized cardiomegaly</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>Feb 15 1966</b> , and that death occurred at <b>124 M</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>Mar 1 1966</b>	
22a. SIGNATURE <b>George A. Boinis</b>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> NAME (Type) <b>George A. Boinis, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/4/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cem.</b> 23d. LOCATION (City, town or county) (State) <b>Silver Spring, Md.</b>
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland	25a. REC'D BY REGISTRAR DATE MAR 7 1966 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

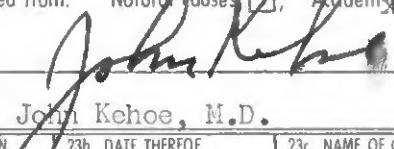
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 along with the State Department of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

04130		04120	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4521 Banner Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Debra		First Lynn	Middle Bailey
S. SEX female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME Roland J. Bailey		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9160 DUE TO Asphyxiation		17. INFORMANT Roland J. Bailey-father Address same as 2	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Inhalation of smoke		INTERVAL BETWEEN ONSET AND DEATH minutes	
DUE TO		minutes	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			
20a. EXTERNAL CAUSE WAS PRIMAR <sup>D</sup> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trapped in upstairs room by house fire.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:00PM p.m. 8 March 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House
20f. (City or town) Brentwood		(County) (State) P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Ridgewood, town or county)	
EXAMINER'S NAME (Type) John Kchoe, M.D.		22. DATE SIGNED 3-9-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 3-15-66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National
24. FUNERAL DIRECTOR John Rhines Company 3015 12th Street, N.W., Wash., D.C.		ADDRESS	25a. REC'D BY REGISTRAR MAR 14 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

00150

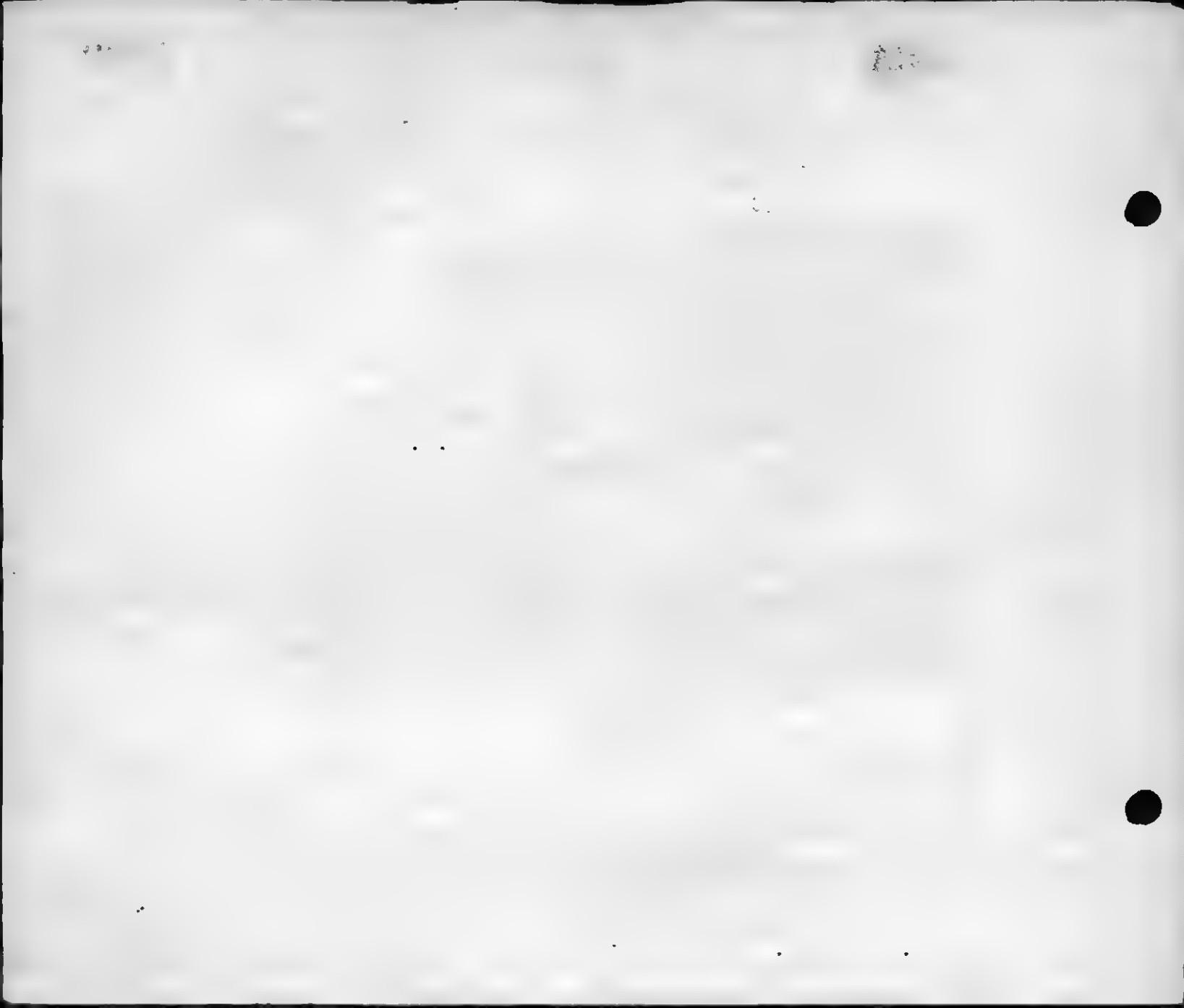
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**04131**

1. PLACE OF DEATH a. COUNTY Prince George		Item 2 Film 3610166 mn		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE D.C. b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md.		c. LENGTH OF STAY IN lb 8 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS 218 2nd St., SE WILLIAM PENN HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELTA		First Middle Last Ballenger		4. DATE OF DEATH March 10, 1966	
5. SEX Male White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11-13-1870	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CHARLES COUNTY, MD USA	
13. FATHER'S NAME JAMES HAYDEN		14. MOTHER'S MAIDEN NAME ELIZABETH BAILEY		12. CITIZEN OF WHAT COUNTRY? Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Jos. H. Barber 133 S St, Charles County, MD 20620	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion		11/2			
DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b) Due to Cardio Vasc - 1st Prod Disease		15 yrs			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1945-19 to 3/10/66, that (I) (we) last saw the deceased alive on 2/13/66, and that death occurred at 10:00 AM, from the causes and on the date stated above.		22b. DATE SIGNED 3/10/66			
22c. PHYSICIAN'S NAME (Type) Harold Heiger MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 1835 Eye St NW DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/12/66		23c. NAME OF CEMETERY OR CREMATORIAL Congressional	
24 FUNERAL DIRECTOR'S SIGNATURE Jos. E. Ryan, Inc.		ADDRESS 317 1/2 Av., SE DC3		25a. REC'D BY REGISTRAR MAR 11 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

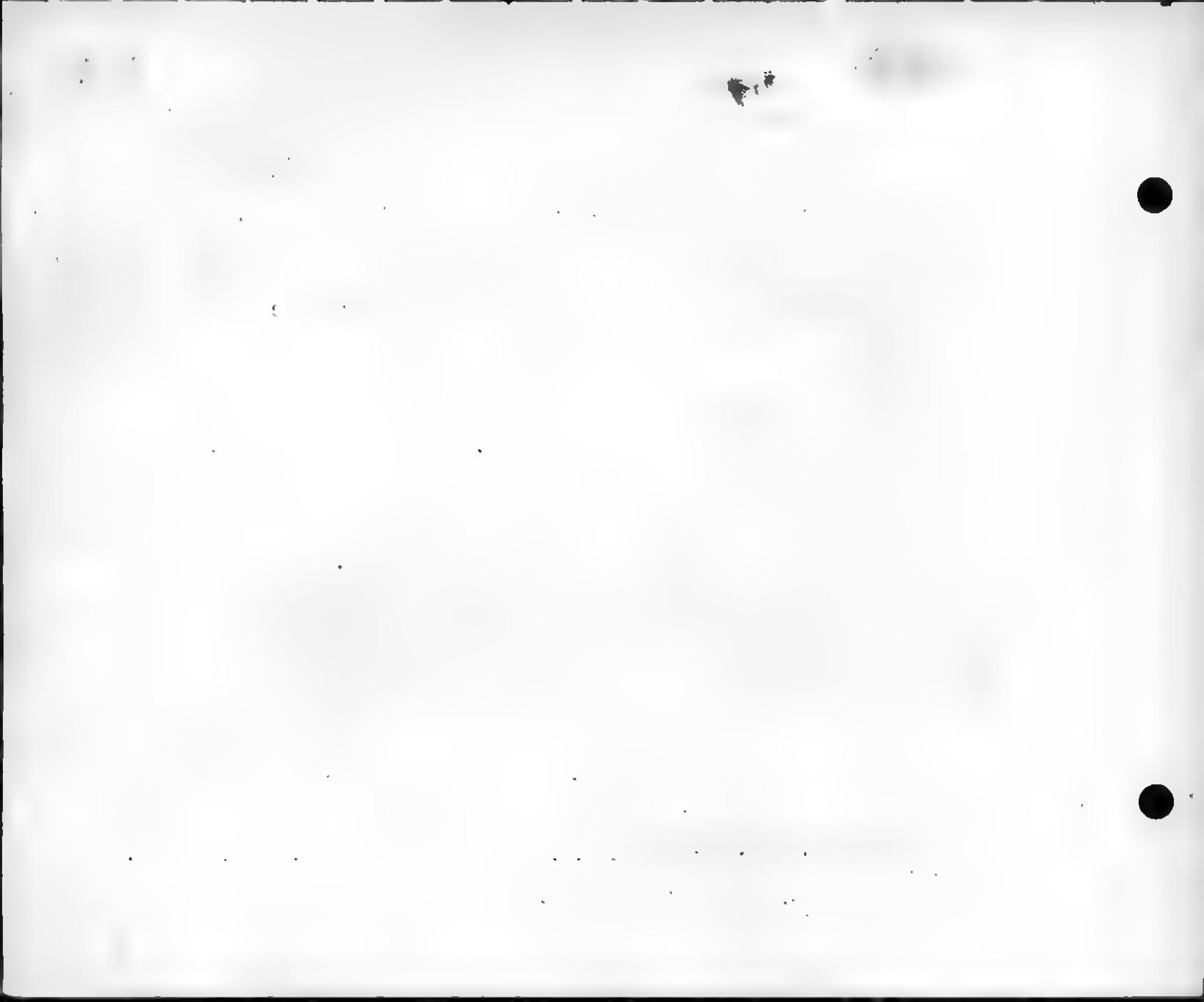
04138 04122

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Levy</b>	Middle	Last <b>Banks</b>
4. DATE OF DEATH	Month <b>March</b>	Day <b>14</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 July 1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>50 yrs.</b>
		11. BIRTHPLACE (County & State, or foreign country) <b>N.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Willard Leslie</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Banks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Bertrice Banks</b> Address <b>Same as 2d</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Dehydration</b> (c) <b>Shock due to Electrolyte Substances</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)
20f. (City or town) <b>Huntsville</b> (County) <b>Montgomery</b> (State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3-10, 1966</b> to <b>3-18, 1966</b> , that (I) (we) last saw the deceased alive on <b>3-13, 1966</b> , and that death occurred at <b>5:00 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Sahakyan</b>		22b. DATE SIGNED <b>3/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Channes Sahakyan, M.D.</b>		22d. ADDRESS <b>5813 Landover Rd. Cheverly, Md.</b>	
23a. BURIAL/CREMATION/REMOVAL (Specify) <b>Harmony Mem. Park</b>		23b. DATE THEREOF <b>3/18/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Huntsville, Md.</b>
24. FUNERAL DIRECTOR <b>HS Washington Cor 4925 Leaven Ave. 715</b>		25a. ADDRESS	25b. LOCATION (City, town or county) (State) <b>Huntsville, Md.</b>
		25c. REC'D BY REGISTRAR <b>Charles Judge</b>	25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.M  
84138

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04123

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DCA		2. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) a. STATE Maryland		b. COUNTY Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princeton			
3. NAME OF DECEASED (Type or print) Elizabeth Morrissey		First	Middle	Last	4. DATE OF DEATH 3	Month	Day	Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED WOMOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 11-1-08	9. AGE (In years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hrs	Min
10a. USUAL OCCUPATION (Give kind of work done during last 6 months, working life, even if retired) G.M.C. (Gem)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, Va.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Frank J. Morrissey		14. MOTHER'S MAIDEN NAME Mary Eliz. Millholland							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO 579-48-7152		17. INFORMANT Chas. Morrissey		6014- <sup>Apartment</sup> Fifth Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure  5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) Cor Pulmonale DUE TO (c) Pulmonary Embolism				INTERVAL BETWEEN ONSET AND DEATH over 3 mo.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street off a bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED 3-7-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/66		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery		23d. LOCATION (City or Town) Richmond		(County) (State) Va.	
24. FUNERAL DIRECTOR Funeral Home Inc.		ADDRESS Nalley's		25a. REC'D. BY REGISTRAR MAR 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## **CERTIFICATE OF DEATH**

04124

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 FOR STATE  
HEALTH DEPT.

04135

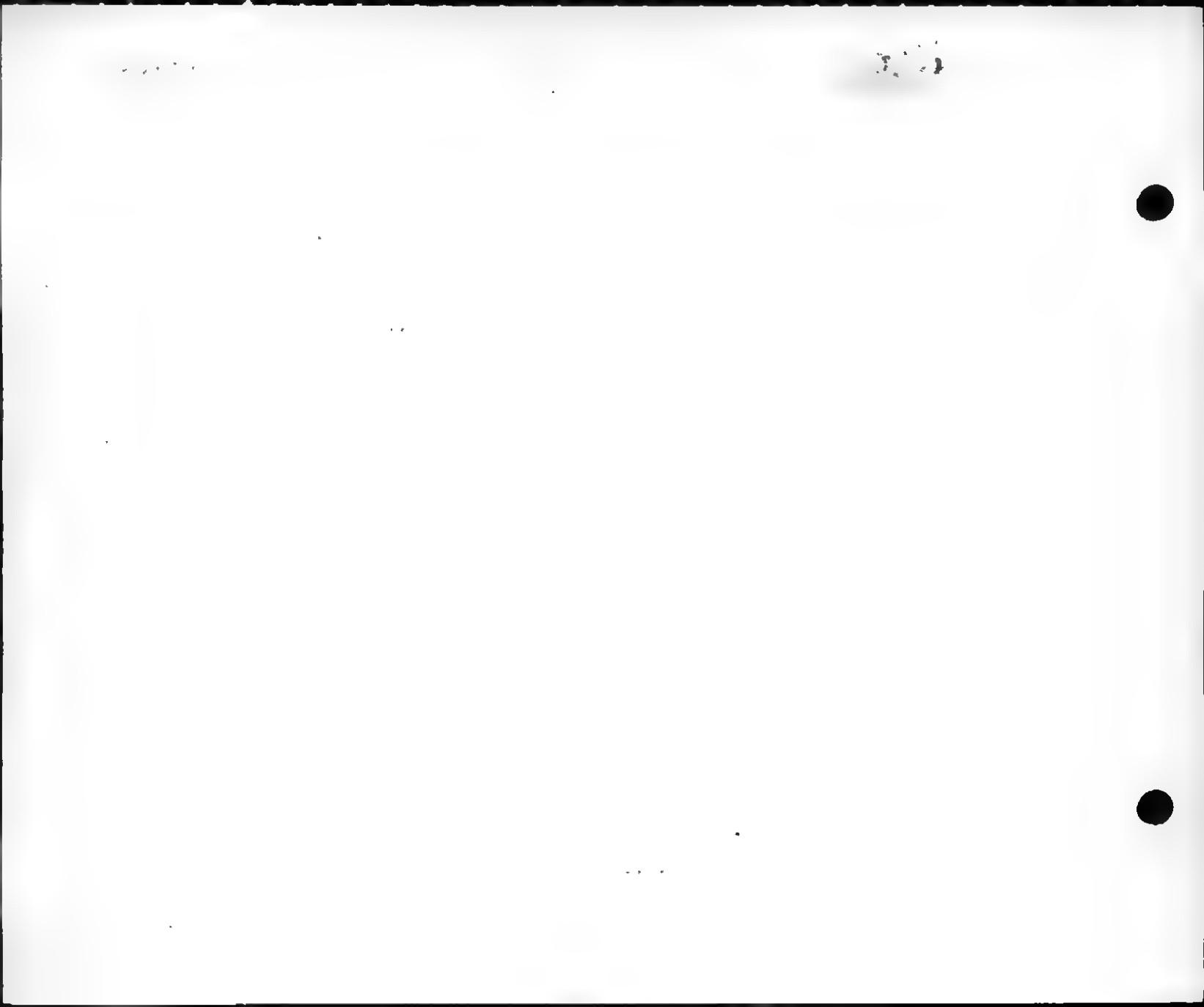
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04125

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Check Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>Md.</b>		f. INSTITUTION RESIDENCE BEFORE ADMISS. ON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN Tb <b>DOA</b>		b. COUNTY <b>Prince George</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Heights</b>			
				d. STREET ADDRESS <b>625 57th Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Thomas Eugene Beavers</b>		First	Middle	Last	4. DATE OF DEATH <b>3 19 1966</b>	Month	Day Year
S. SEX <b>M</b>	6. COLOR OR RACE <b>Tan</b>	7. MARRIED WIDOWED <b>Divorced</b>	NEVER MARRIED <b>Divorced</b>	8. DATE OF BIRTH <b>24 Feb., 1872</b>	9. AGE (In years last birthday) <b>94 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	F. UNDER 24 HRS Days <b>0</b>
10. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railway express</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES BEAVERS</b>				14. MOTHER'S MAIDEN NAME <b>MARY N KIDWELL</b>		Address <b>625 57th Ave. EVERETT G. BEAVERS SR. CAPITAL MHS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>EVERETT G. BEAVERS SR.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>min.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic heart disease</b>		DUE TO (b) <b>unknown</b>					
DUE TO (c)							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>3-20-66</b>	
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-23-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>FAIRFAX</b>		23d. LOCATION (City or Town) (County) (State) <b>FAIRFAX, VA</b>	
24. FUNERAL DIRECTOR <b>EVAN CHAMBERS 517 11th ST SE WASH. DC</b>		ADDRESS		25a. REG'D BY REGISTRAR <b>DAR 28 1956</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



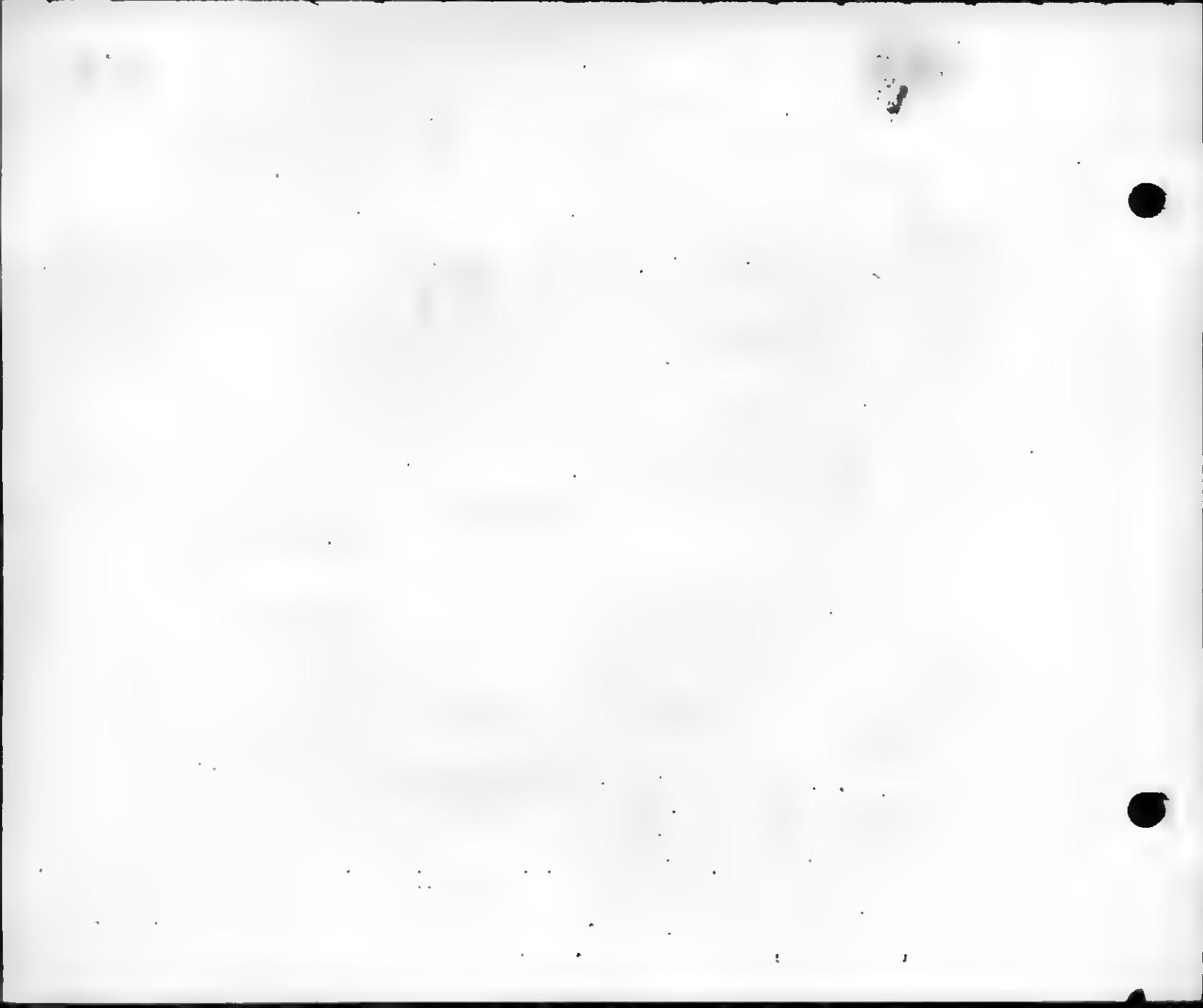
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

M 04136 04126

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN MD <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6107 Ruatan St.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>Berwyn Heights,</b>				
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Johanna</b>	4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <b>June 20, 1892</b> Day <b>73</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <b>Slovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Michael Sebesi</b>		14. MOTHER'S MAIDEN NAME <b>Anna Simian</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>Irene E. Hill</b> , #2 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO (b)  DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Acute myocardial infarction Arterio-sclerotic Heart disease</b> 9/8/66				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory, street, office bldg., etc.	20f. (City or town) 3-1-66, 19	(County) 3-3-66, 19	(State) 3-3-66, 19
21. I certify that (I) (this hospital) attended the deceased from <b>3-1-66, 19</b> to <b>3-3-66, 19</b> , that (I) (we) last saw the deceased alive on <b>3-3-66, 19</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.				22b. DATE SIGNED <b>3 March, 1966</b>		
22a. SIGNATURE <i>William C. Weintraub</i>		22c. PHYSICIAN'S NAME (Type) <b>William C. Weintraub, M.D.</b>		22d. ADDRESS <b>Prof. Bldg. Centerway, Greenbelt, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-7-66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Cathedral</b>	23d. LOCATION (City, town or county) <b>Scranton, Penna.</b>		
24. FUNERAL DIRECTOR <b>Jas. T. Ryan, Inc.</b>		ADDRESS <b>317 Fa. Ave., SE DC 31</b>	25a. REC'D BY REGISTRAR <b>DATE</b>		25b. REGISTRAR'S SIGNATURE <b>Jas. T. Ryan, Inc.</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if convenient, within 72 hours after death.

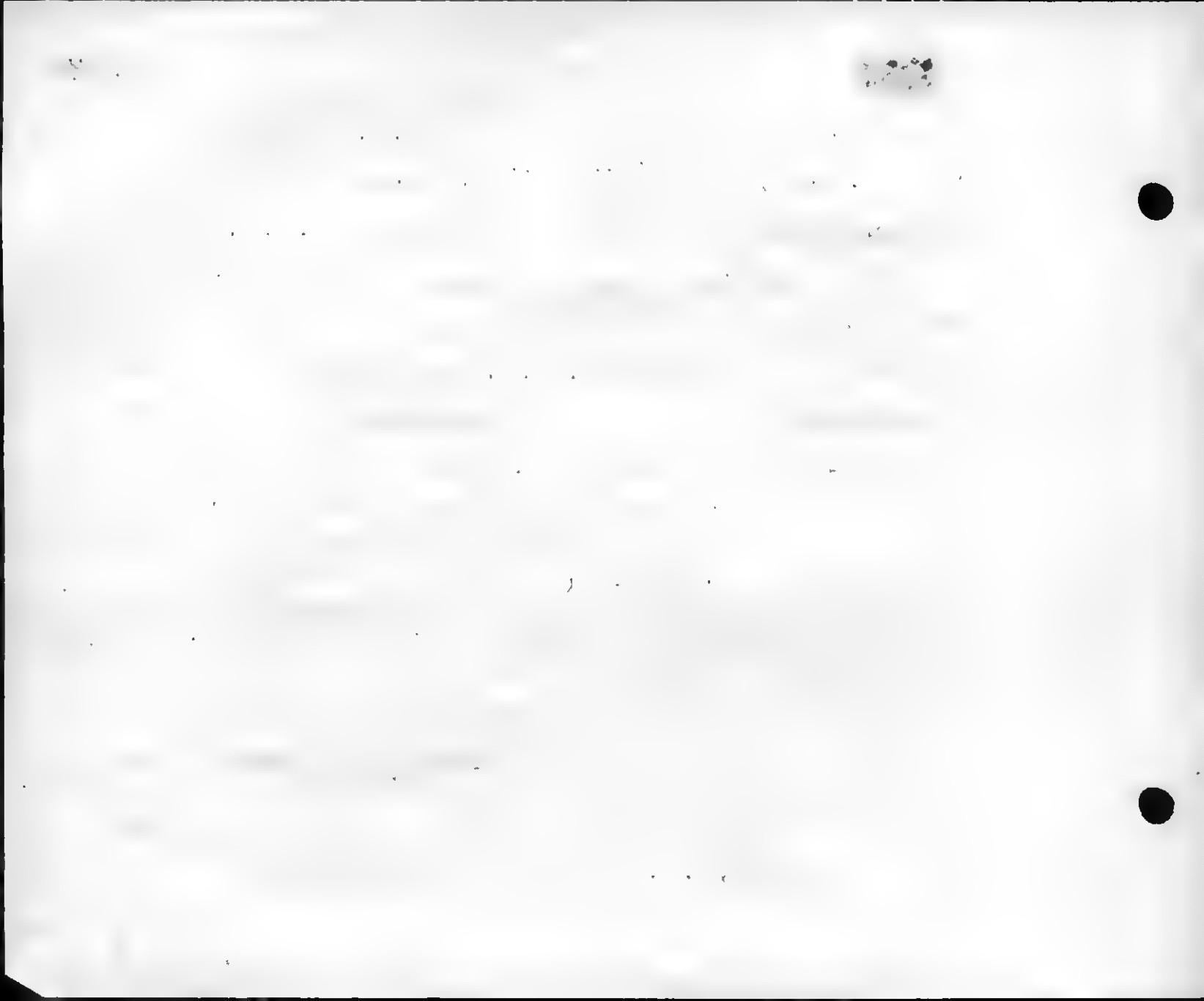
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04128

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D. C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>			c. LENGTH OF STAY IN lb <b>3 yrs., 11 mo. 18 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
3. NAME OF DECEASED (Type or print) <b>Willie James Bender</b>			d. STREET ADDRESS <b>725 Atlantic St. S. E.</b>		
3. NAME OF DECEASED (Type or print) <b>Willie James Bender</b>		First <b>Willie</b>	Middle <b>James</b>	Last <b>Bender</b>	4. DATE OF DEATH <b>March 19 1966</b>
S SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <b>Separated</b>	NEVER MARR ED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/15/1934</b>	9. AGE (in years last birthday) <b>31 yrs</b>
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Air Construction Co., D. C.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Selma, Alabama</b>	
13. FATHER'S NAME <b>Willie MacMillan</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Bender</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>418-42-3401 unknown</b>		17. INFORMANT <b>Decedent</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pyelonephritis of right kidney with renal failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> DUE TO (b) <b>Status post bilateral uretero-ileostomy</b> 12 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Quadriplegia (upper paresis, lower paralysis)</b> 9 yrs. (d) <b>secondary to fracture C-7, traumatic</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Tracheostomy with bleeding into bronchial tree; cystotomy, remote.</b>					
19. WAS AN AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>March 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Glenn Dale Hospital</b>	20f. (City or town) <b>T. D.</b>	(County) <b>T. C.</b>
21. I certify that <b>(he)</b> (this hospital) attended the deceased from <b>March 28, 1962</b> , to <b>March 19, 1966</b> that <b>we</b> (we) last saw the deceased alive on <b>March 19, 1966</b> , and that death occurred at <b>7:30 A.M.</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Moe Weiss</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/19/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>3-28-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>42nd Cemetery, T. C.</b>	23d. LOCATION (City or Town) <b>T. D.</b>	(County) <b>T. C.</b>
24. FUNERAL DIRECTOR <b>E.T. Morris</b>		ADDRESS <b>National Funeral Home 412-H St NE</b>	25a. REC'D BY-REGISTRAR <b>Mar 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>
VR A15 (4) 20 M 1/64			DATE		





MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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04138

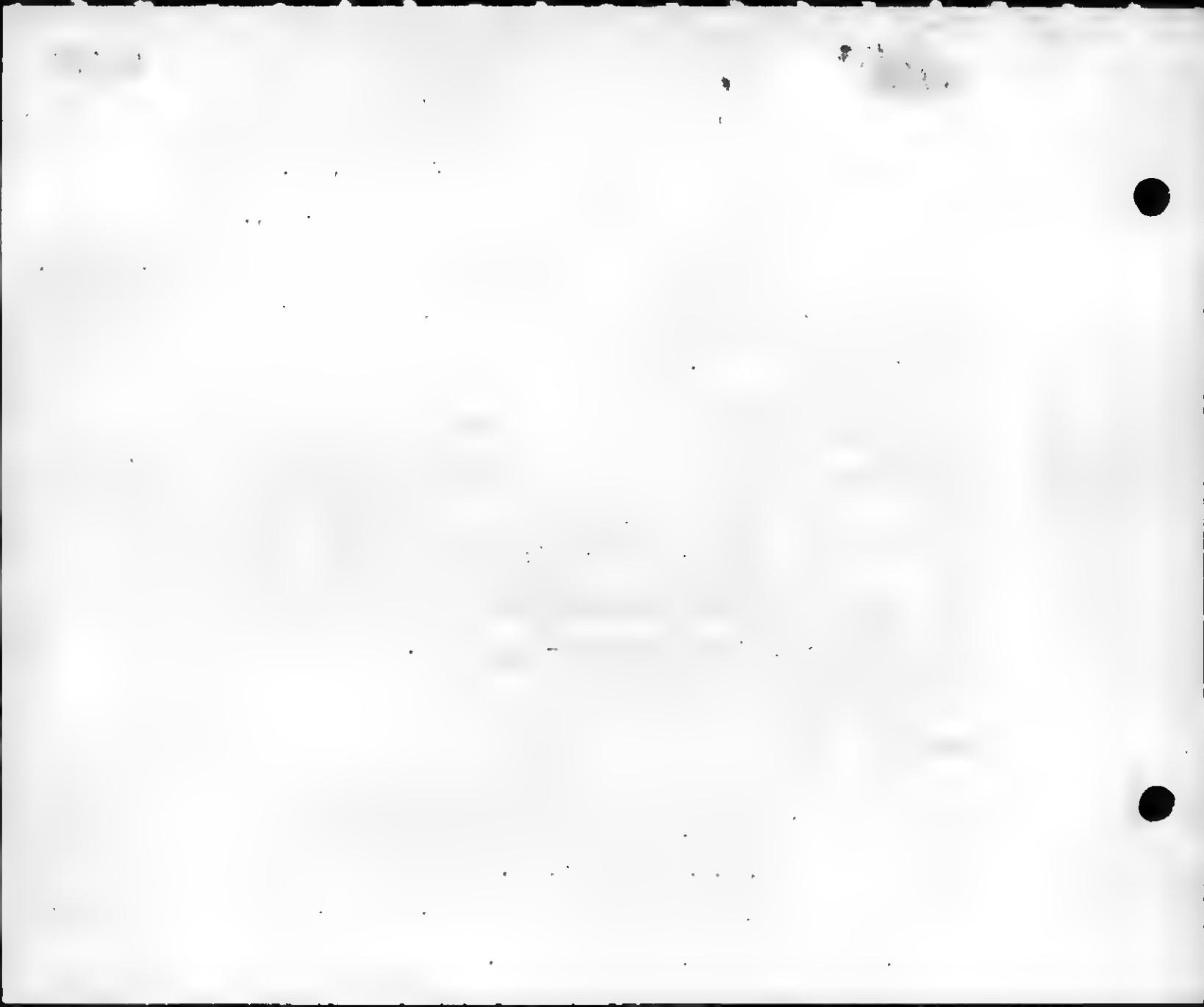
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

99

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <b>Prince George's MARYLAND</b>		a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. LENGTH OF STAY IN lb <b>DCA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>First Josephine</b>		4. DATE OF DEATH Last Month Day Year <b>Benesh March 26, 1966.</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <b>X</b> MARRIED WIDOWED DIVORCED		8. DATE OF BIRTH <b>Aug 29, 1892</b>	
9. AGE (In years last birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 0 0 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Callagy</b>		14. MOTHER'S MAIDEN NAME <b>Anna Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578 30 6012</b>	
17. INFORMANT <b>Joseph Benesh</b>		Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH minutes <b>4/300</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic heart disease</b>		unknown	
(b) DUE TO <b>Metastatic carcinoma of breast - over 5 yrs.</b>			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Primary cause of death</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Metastatic carcinoma of breast - over 5 yrs.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. D.M.                    19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Riverdale, Md. Prince George's County Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kelcey, M.D.</b>		22. DATE SIGNED <b>3-28-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 30, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Grove Church Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>North Bergen New Jersey</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		ADDRESS	
		25a. REC'D BY REGISTRAR <b>DATE MAR 20 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Albany Judge</b>	



1 M  
FOR STATE  
HEALTH DEPT.

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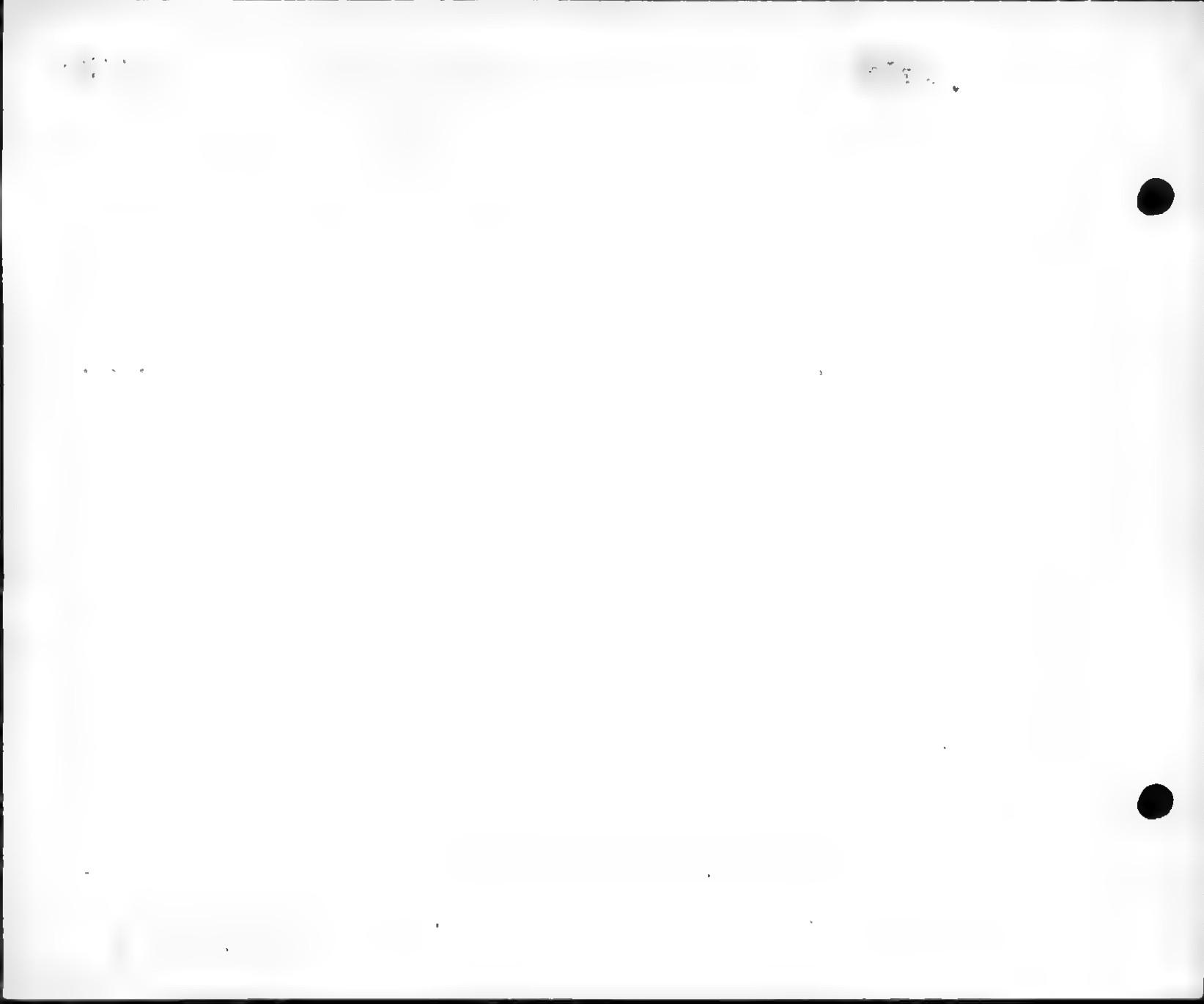
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04130

1 PLACE OF DEATH a COUNTY <b>Prince George's</b>		2 USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) b STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN lb <b>2 hrs 35 min</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George General Hospital</b>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
3 NAME OF DECEASED (Type or print) <b>James Bernard Benney</b>		4 DATE OF DEATH Month <b>3</b>	Month Day Year <b>21 1966</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Wash. Term. RR</b>		8. DATE OF BIRTH <b>10-15-1889</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		9 AGE (In years lost birthday) <b>76 yrs</b>	
13 FATHER'S NAME <b>George E. Benney</b>		10 BIRTHPLACE (State or foreign country) <b>Centreville, Md.</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>No</b>		11 COUNTRY OF WHAT COUNTRY? <b>U.S.A.</b>	
16 SOCIAL SECURITY NO		17 INFORMANT Address <b>Mrs. Clara E. Benney (above address) (wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of chest</b> 176X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONNOTED IN PART I(o)			
20b EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20c TIME OF INJURY Month, Day, Year Hour a.m. <b>1:35 pm pm 3-21- 1966</b>	
20d PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Shot self at home</b>		20e (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b DATE THEREOF <b>3/25/66</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Centreville Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Centreville, Md.</b>	
24 FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a ADDRESS <b>117 Rainier, Maryland</b>	
		25b REC'D BY REGISTRAR DATE <b>MAR 28 1966</b>	
		25c REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death.

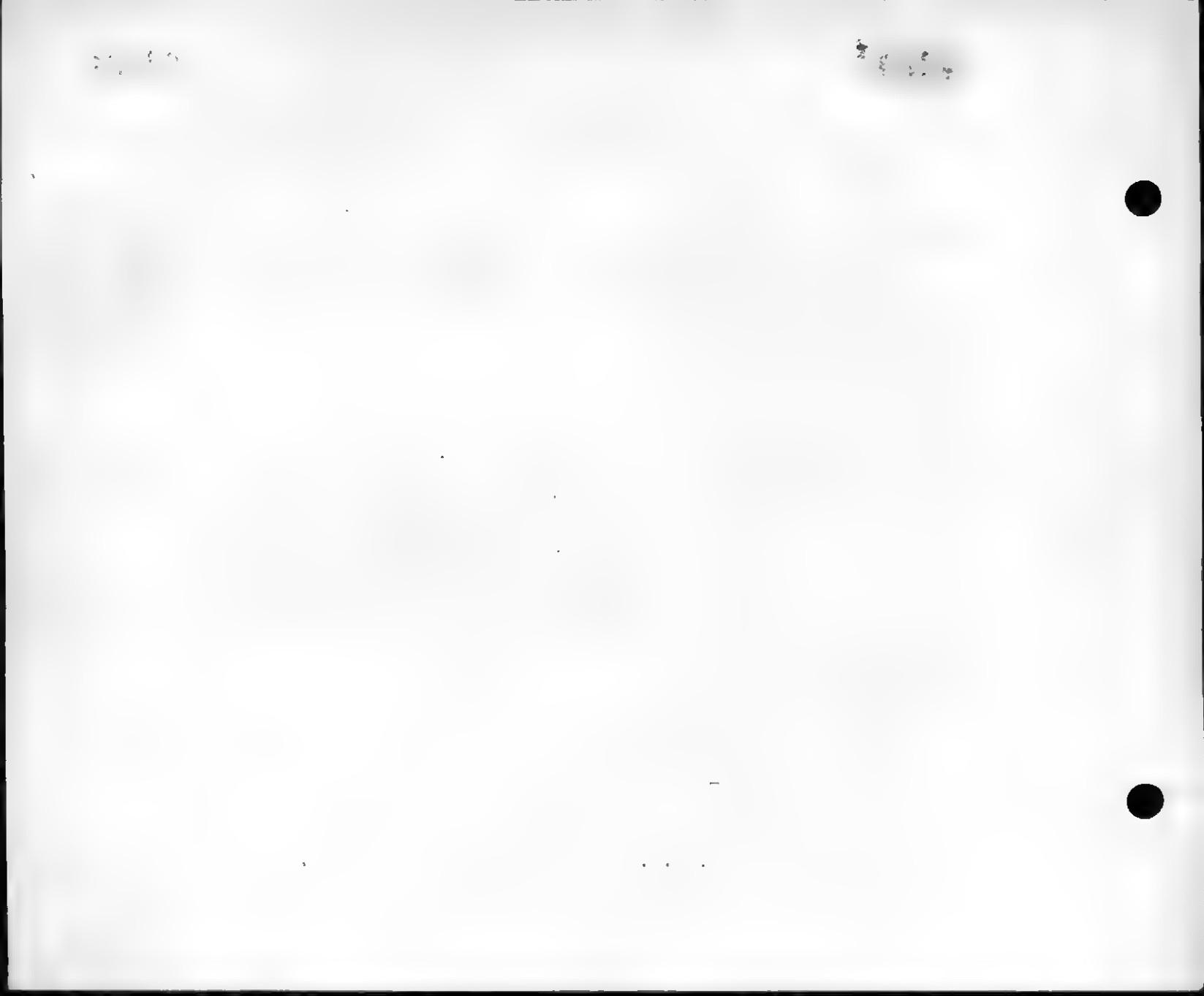
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY  Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines		d. STREET ADDRESS 5404 Newby Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5408 Newby Ave				5. NAME OF DECEASED (Type or print) ANNA OLIVIA BOYD		4. DATE DEATH March 2 19 66			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. OATE OF BIRTH Apr 23, 1896		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Andrew Angus MacDnnis		14. MOTHER'S MAIDEN NAME Susan Harrison		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs Olivia Andres	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) From carcinoma of the pancreas							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-28-66, 19, to 3-2-66, 19, that (I) (we) last saw the deceased alive on 3-2-66, 19, and that death occurred at 1:30 P.M. from the causes and on the date stated above.		22b. DATE SIGNED Mar 2, 1966							
22a. SIGNATURE 		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> ADDRESS Riverdale, Md.							
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.									
23a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) Burial Mar 7, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National		23d. LOCATION (City, town or county) Arlington, Virginia		(State)			
24. FUNERAL DIRECTOR Lee Funeral Home, 4th and Mass NE, Wash, D.C.				25a. REC'D BY REGISTRAR MAR 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
				DATE					



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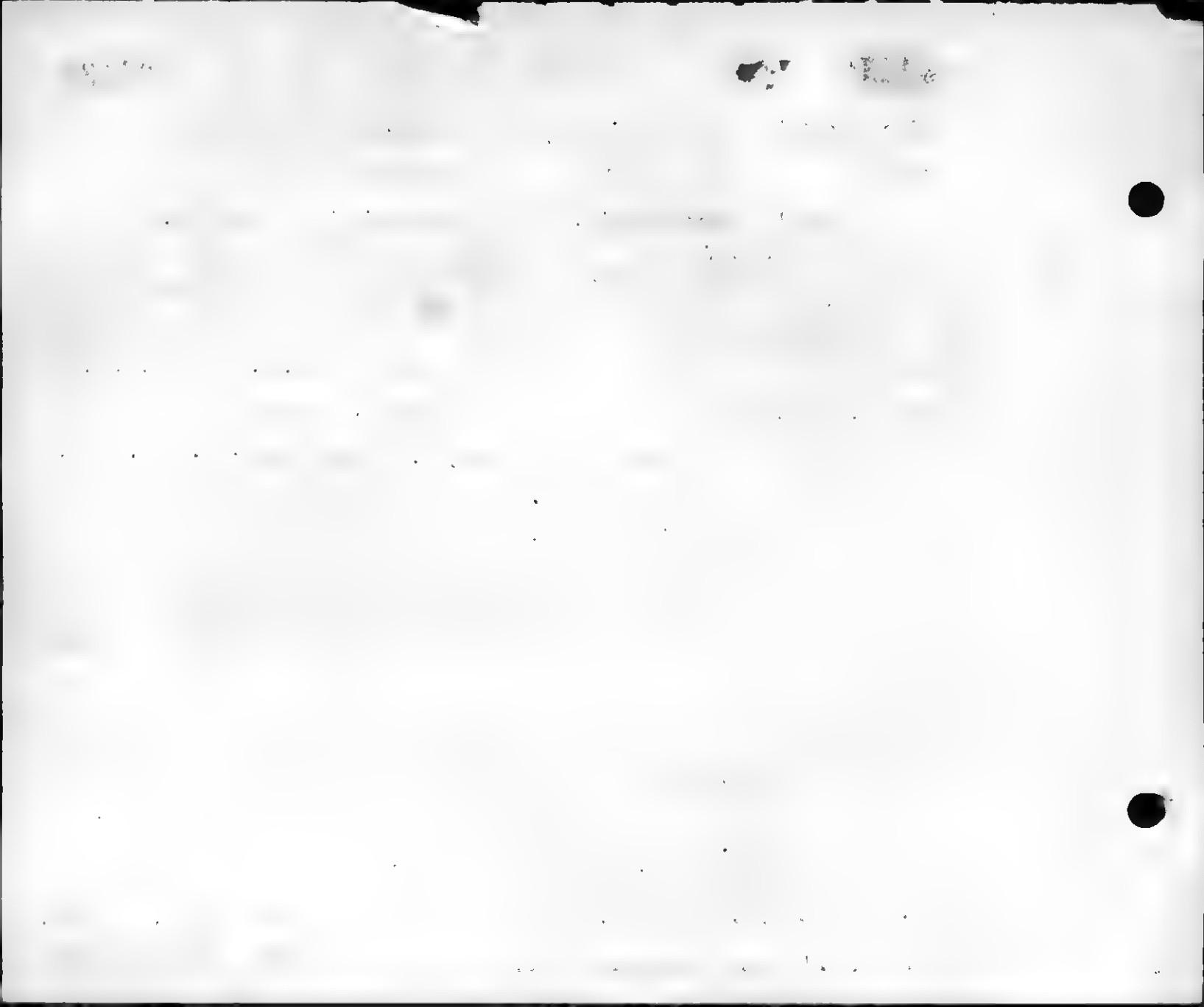
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04132

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4610 Whitfield Chapel Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Virginia</b>	Middle <b>Mary</b>	Last <b>Brewer</b>
4. DATE OF DEATH Month <b>March</b>	Day <b>17</b>	Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1965</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harvey O. Brewer</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn L. Donaldson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <b>no</b>		16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>none</b> <b>Harvey O. Brewer Same as #2 Father</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, If any, which give rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>Bronchopneumonia</i> <i>Inter Ventricular Septal Defect</i> <i>Mongolism</i>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 14, 1966</b> , to <b>March 17, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 17, 1966</b> , and that death occurred at <b>1:32 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>3-18-66</b>	
22a. SIGNATURE <i>Bernard Alvarado</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> PM MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS <b>6201 Riverdale Rd, Md.</b>
22c. PHYSICIAN'S NAME (Type) <b>Bernard Alvarado</b>		23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3/19/66</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Ft. Lincoln</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		23d. LOCATION (City, town or county) (State) <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

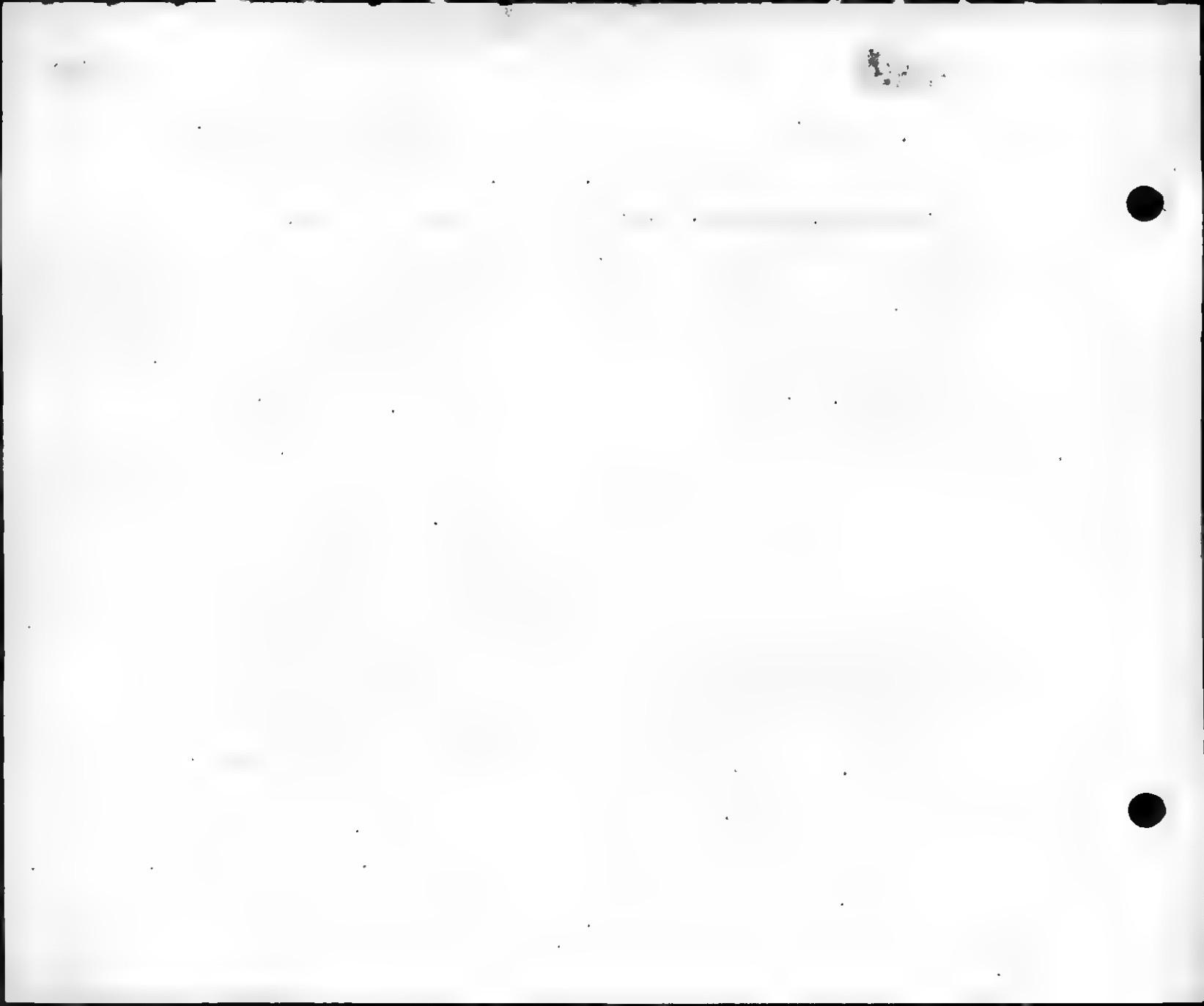


**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

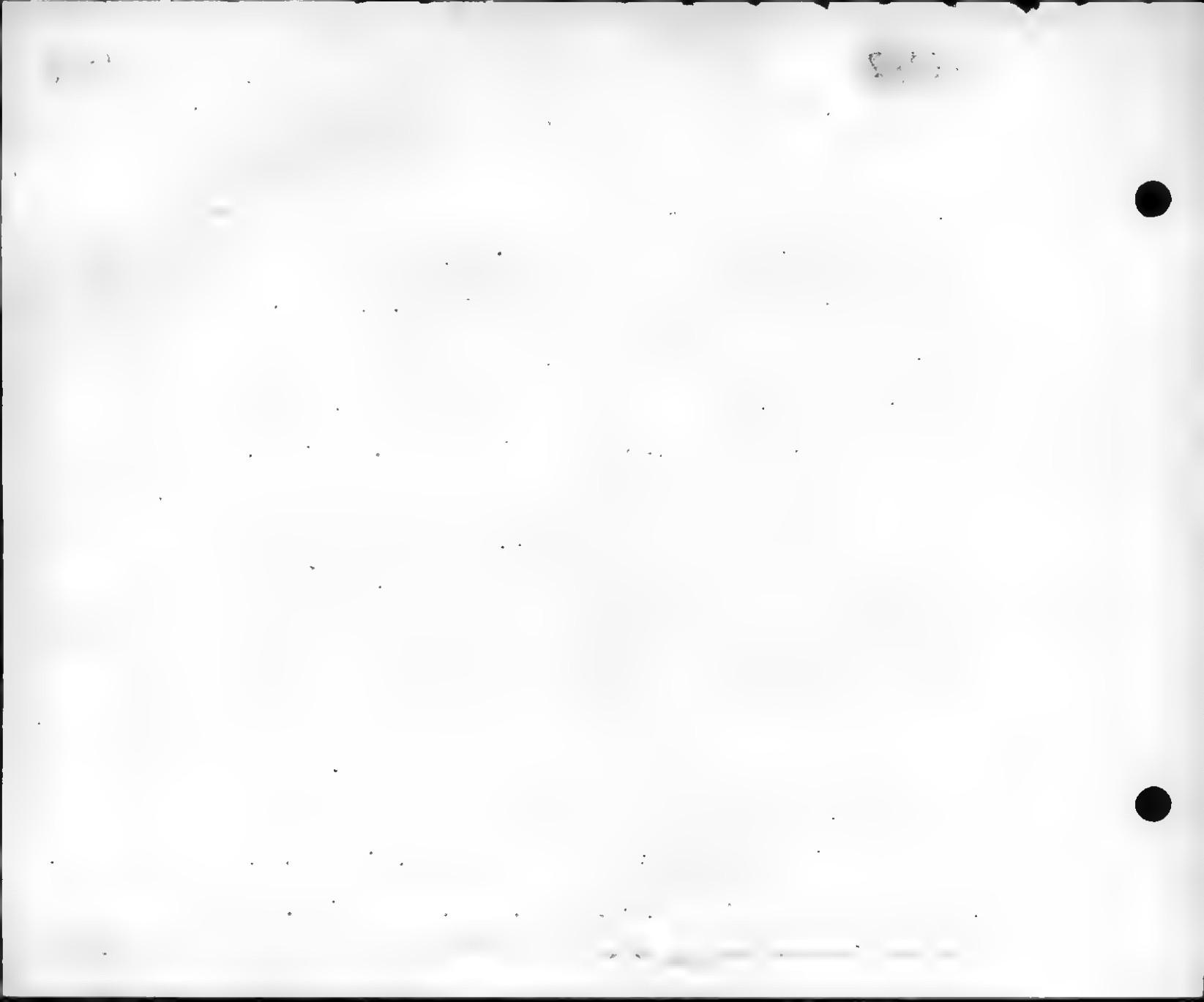
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												04133							
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)															
a. COUNTY <b>Prince George's</b> MARYLAND				a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>12 hr. 48 min.</b>															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Baby</b>				First <b>Baby</b>	Middle <b>Girl</b>	Last <b>Britt</b>	4. DATE OF DEATH <b>March 15 1966</b>	Month <b>March</b>	Day <b>15</b>	Year <b>1966</b>									
5. SEX <b>Female</b>				6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1966</b>	9. AGE (in years last birthday) <b>yrs.</b>	10. UNDER 1 YEAR <input type="checkbox"/> Months <b>12</b>	11. UNDER 24 HRS. <input type="checkbox"/> Days <b>48</b>	Hours <b>12</b>	Min. <b>48</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>								11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Leon Thomas Britt</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Ann McClurkin</b>								Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>--</b>								17. INFORMANT <b>Mother</b>				Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												PremaSucty							
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.												Probable cause basis							
DUE TO (b) (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Prince Geo. General Hospital, Cheverly, Md.</b>				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1966</b> , to <b>March 15 19 66</b> that (I) (we) last saw the deceased alive on <b>March 15 19 66</b> , and that death occurred at <b>1:05 PM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <i>J. Hernandez</i>												22b. DATE SIGNED <b>3-17-66</b>							
22c. PHYSICIAN'S NAME (Type) <b>J. Hernandez</b>				22d. ADDRESS <b>Prince Geo. General Hospital, Cheverly, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3-19-66</b>								23c. NAME OF CEMETERY OR CREMATORIAL <b>HARMONY ME. PARK</b>				23d. LOCATION (CITY, TOWN OR COUNTY) (STATE) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Louie S. Funeral</b>				ADDRESS <b>1425. md. rd.</b>								25a. REC'D. BY REGISTRAR <b>MAR 21 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
6-1-5																			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of remains in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kent Village</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>7302 73rd Court</b>				
3. NAME OF DECEASED (Type or print)			First <b>William</b>	Middle	Last <b>Brodsky</b>	4. DATE OF DEATH <b>March 8 1966</b>	Month <b>March</b>	Day <b>8</b>	Year <b>1966</b>			
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Aug., 1922</b>	9. AGE (in years last birthday) <b>43 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Industry</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles Brodsky</b>												
14. MOTHER'S MAIDEN NAME <b>Edith Katz Brodsky</b>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>			16. SOCIAL SECURITY NO. <b>577-26-7950</b>			17. INFORMANT <b>Lillian C. Brodsky, Wife</b>			Address <b>See 2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Myxedema</b> INTERVAL BETWEEN ONSET AND DEATH												
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart disease</b> (c) <b>old Myxedema infar.</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 7, 1963</b> , to <b>March 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>3-7-1966</b> , and that death occurred at <b>20AM</b> , from the causes and on the date stated above.												
22a. SIGNATURE <b>Paul Angus Devore</b>												
22b. DATE SIGNED <b>3-8-66</b>												
22c. PHYSICIAN'S NAME (Type)		Paul Angus Devore			22d. ADDRESS <b>3415 Hamilton St. W. Hyattsville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11 Mar '66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Arl. Natl. Cem.</b>		23d. LOCATION (City, town or county) <b>Sr. Virginia</b>		(State)				
24. FUNERAL DIRECTOR <b>Hesley Funeral Home 4217-9 &amp; Seco</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>D MAR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						
VR A15 (4) 20M 1/65												

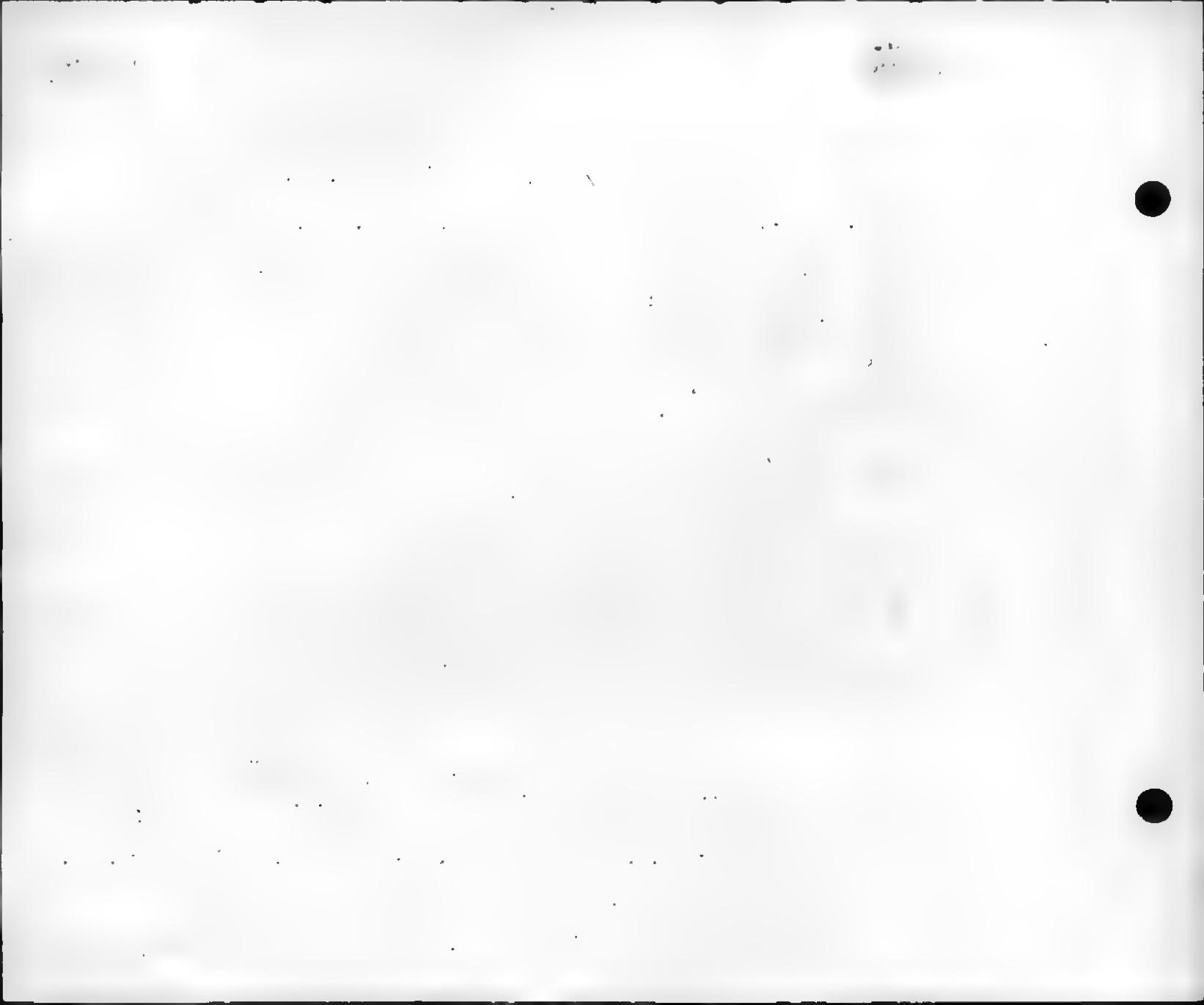


**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

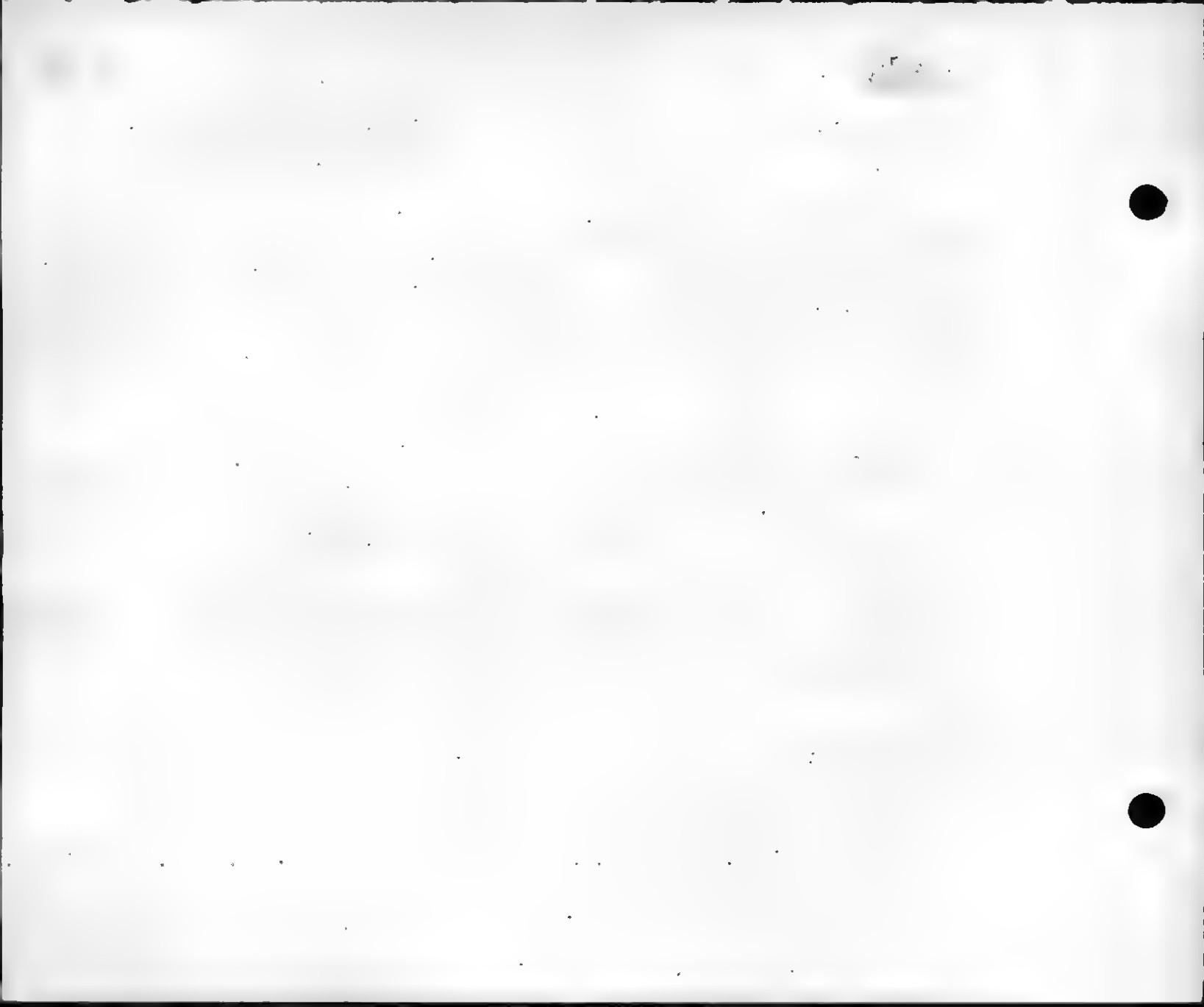
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George</b>	
c. LENGTH OF STAY IN 1B <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Hights.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>74 Prince George General</b>		d. STREET ADDRESS <b>712 67th. Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elmer Brooks</b>	First <b>Male</b>	Middle <b>Negro</b>	Last <b>March</b>
4. DATE OF DEATH <b>12/15/21</b>	Month <b>12</b>	Day <b>19</b>	Year <b>66</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/21</b>
9. AGE (In years last birthday) <b>11 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	14. MOTHER'S MAIDEN NAME <b>Lillian Royster</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>17. INFORMANT</b>	Address <b>Mrs. Grace E. Brooks 712 62nd Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cerebral hemorrhage</b> (b) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>331X</b> (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>March 11, 1966</b> , and that death occurred at <b>5:50 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>3/13/66</b>	
22a. SIGNATURE <b>Peter Duus</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. P.M. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>6124 Central Ave. Capitol Hgts. Md.</b>
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/16/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Lincoln Memorial Ceme</b>
24. FUNERAL DIRECTOR <b>John T. Stewart, Jr.</b>		25a. ADDRESS <b>Stewart Funeral Home 4001 Benning Road,</b>	25b. REC'D. BY REGISTRAR <b>JAN 15 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item No. 166 mh 04136											
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
Prince George's Cheverly		a. STATE Maryland b. COUNTY Prince George's									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
c. LENGTH OF STAY IN 1b		Fairmont Heights									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS									
Prince George's General Hospital		611 62nd Avenue									
3. NAME OF DECEASED (Type or print)		First Ada	Middle	Last Brown	4. DATE OF DEATH	Month March	Day 20	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months 67 yrs.	11. IF UNDER 24 HRS Days Hours Min.				
Female Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
unknown			Unknown								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident - thrombosis											
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Hypertension & Arteriosclerotic Vascular Dis.											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Urinary Tract Infection											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 12, 1966, to March 20, 1966, that (I) (we) last saw the deceased alive on March 20, 1966, and that death occurred at 5:10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE		22b. DATE SIGNED 3/21/66									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Prince George's Genl. Hosp. Cheverly Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/26/66		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Service		23d. LOCATION (City, town or county) Cheverly		(State)			
24. FUNERAL DIRECTOR		ADDRESS Brown & Davison 5635 Eds Rd. SE		25a. REC'D BY REGISTRAR MAR 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 20M 1/65											



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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04146

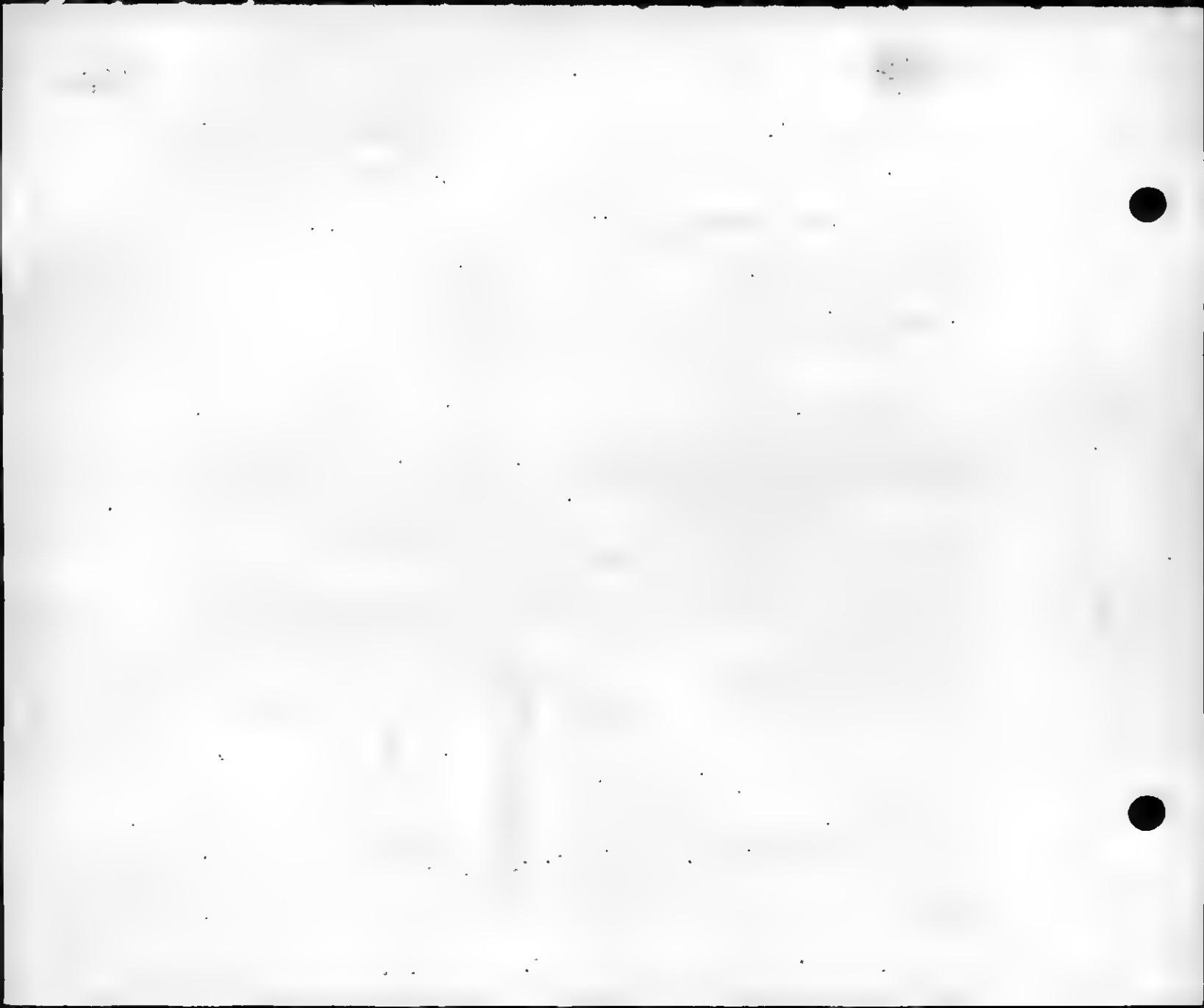
## CERTIFICATE OF DEATH

04137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>5504 Volta Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Helen</b>	Middle <b>J</b>	Last <b>Brown</b>
4. DATE OF DEATH	Month <b>3</b>	Day <b>2</b>	Year <b>1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-19-04</b>
9. AGE (In years last birthday) <b>61 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Government Print. D.C.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
13. FATHER'S NAME <b>Claude M. Brown</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Strahnn</b>	Address <b>Md. 5504 Volta Ave. Blad</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>215-44-8485</b>	17. INFORMANT <b>Claude W. Brown</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, arteriosclerotic heart disease</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Many years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6372 Linville Rd., Cheverly, Md.</b>
20f. (City or town) <b>3/2/66</b>		(County) (State) <b>3/2/66</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/20, 1966</b> , to <b>3/2, 1966</b> , that (I) (we) last saw the deceased alive on <b>3/2, 1966</b> , and that death occurred at <b>3SP M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick H. Wilhelm</b>		22b. DATE SIGNED <b>3/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frederick H. Wilhelm, M.D.</b>		22d. ADDRESS <b>6372 Linville Rd., Cheverly, Md.</b>	22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>3/2/66</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-5-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>
23d. LOCATION (City, town or county) <b>Suitland, Md.</b>		(State)	
24. FUNERAL DIRECTOR <b>Lee Funeral Home 300 4th St. N.E., Wash.</b>		25a. ADDRESS <b>DATE</b>	25b. REC'D BY REGISTRAR <b>MAR 7 1966</b>
		REGISTRAR'S SIGNATURE <b>Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

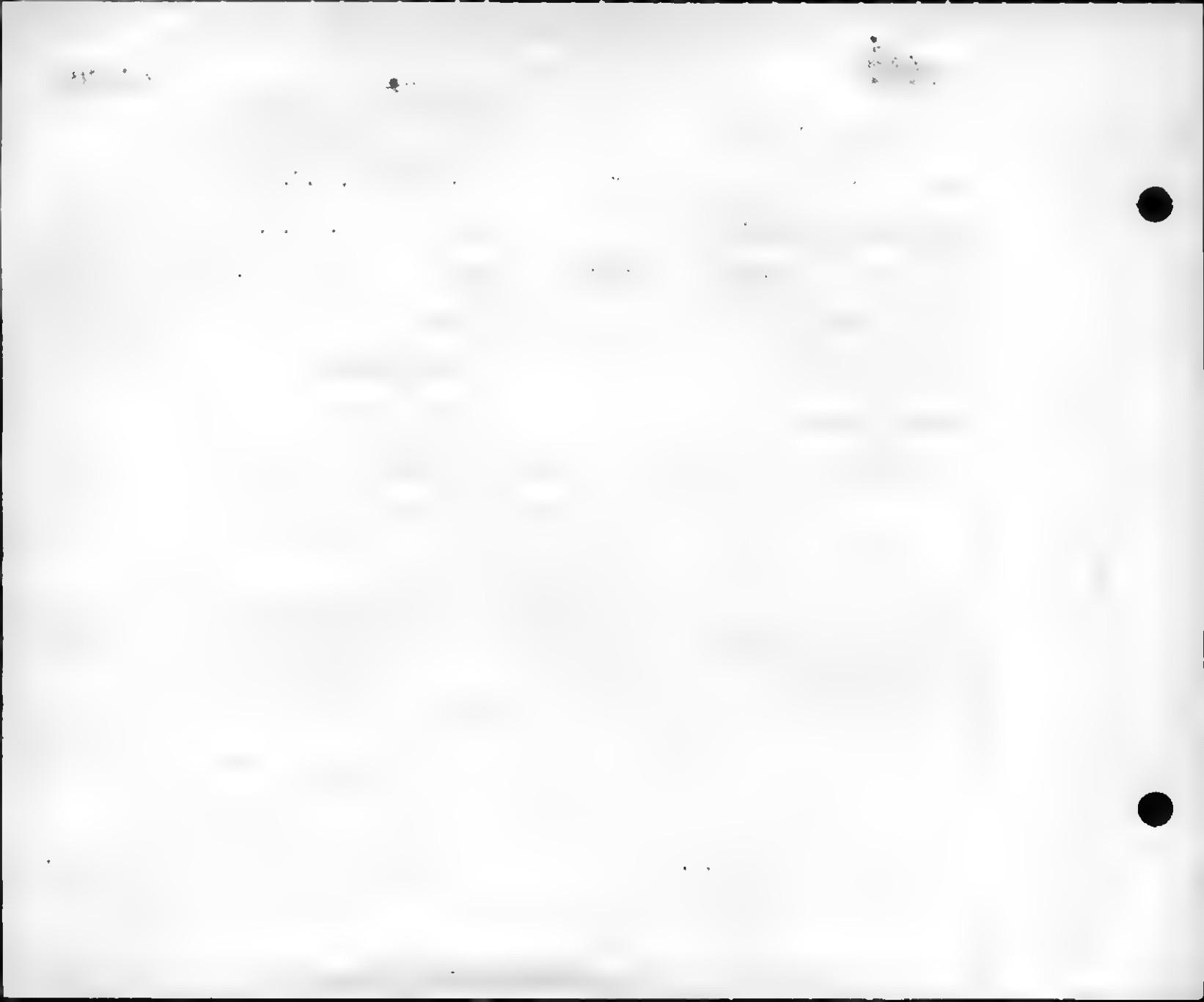
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

03147 04138

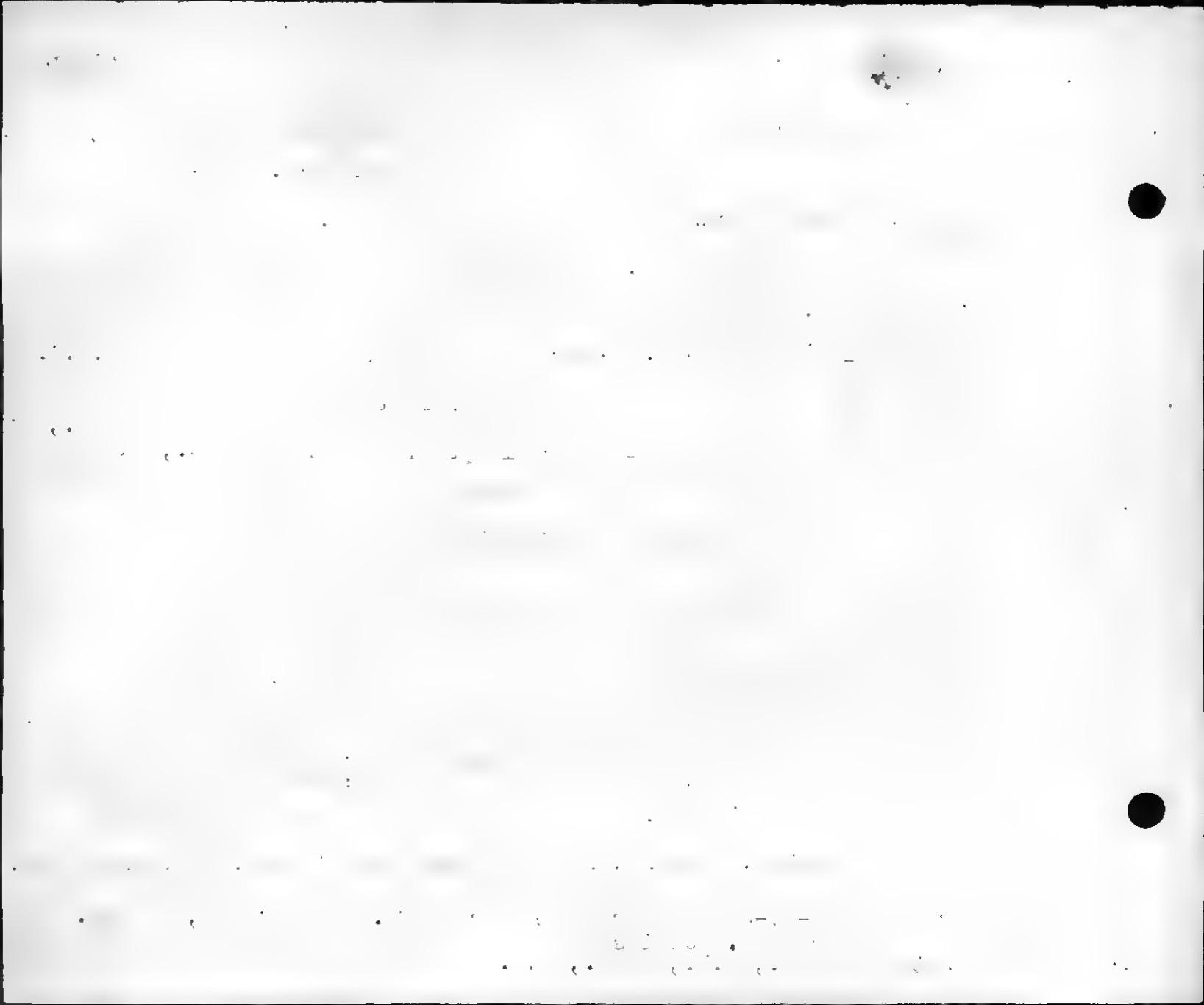
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>	c. LENGTH OF STAY IN Tb <b>2 yr 6 mo</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>724 Hobart Pl., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>William</b>	Last <b>Brown</b>
4. DATE OF DEATH <b>March 30, 1966</b>	Month Last	Day 30	Year 1966
5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>5/8/1874</b>		9. AGE (In years last birthday) <b>91 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Brown</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>?</b>	
17. INFORMANT <b>decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ stating the underlying cause (c) <b>Pulmonary tuberculosis</b>		2 yr. 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (g) <b>Pulmonary fibrosis and emphysema; carcinoma of prostate; generalized arteriosclerosis; chronic pyelonephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/27/1963</b> , to <b>3/30/1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/30/1966</b> , and that death occurred at <b>1:00PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED <b>3/30/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/4/1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>M.E. Jarvis co</b>		ADDRESS <b>1432 - You St. NW</b>	
		25a. REC'D BY REGISTRAR <b>APR 4 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in my absent, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Item 7 File # 04138 3/21/66 pg. 1													
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1D <b>2 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>John</b>	Middle <b>C.</b>	Last <b>Brown</b>	4. DATE OF DEATH 3 20 1966	Month	Day	Year					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>C.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/86	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garage -</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Driver</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UKN</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>577 10 7614</b>				17. INFORMANT <b>Gladys Brown</b>				Address <b>6110 1/2 H St., Fairmont Hgts., Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Subarachnoid hemorrhage</b>													
IMMEDIATE CAUSE (a) <b>3301</b>													
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b>													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Landover</b>		(County) <b>Md.</b>		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 18, 1966</b> , to <b>March 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 20, 1966</b> , and that death occurred at <b>10:00 P.M.</b> the causes and on the date stated above.													
22a. SIGNATURE <b>Edwin J. Jensen</b>													
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>				22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly Md.</b>				22b. DATE SIGNED <b>3/21/66</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-23-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony Memorial Pk.</b>		23d. LOCATION (City, town or county) <b>Landover</b>				(State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Myrtle K. Rollins</b>		ADDRESS <b>4339 Hunt Pl., N.E., Wash., D.C.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



## MARYLAND STATE DEPARTMENT OF HEALTH

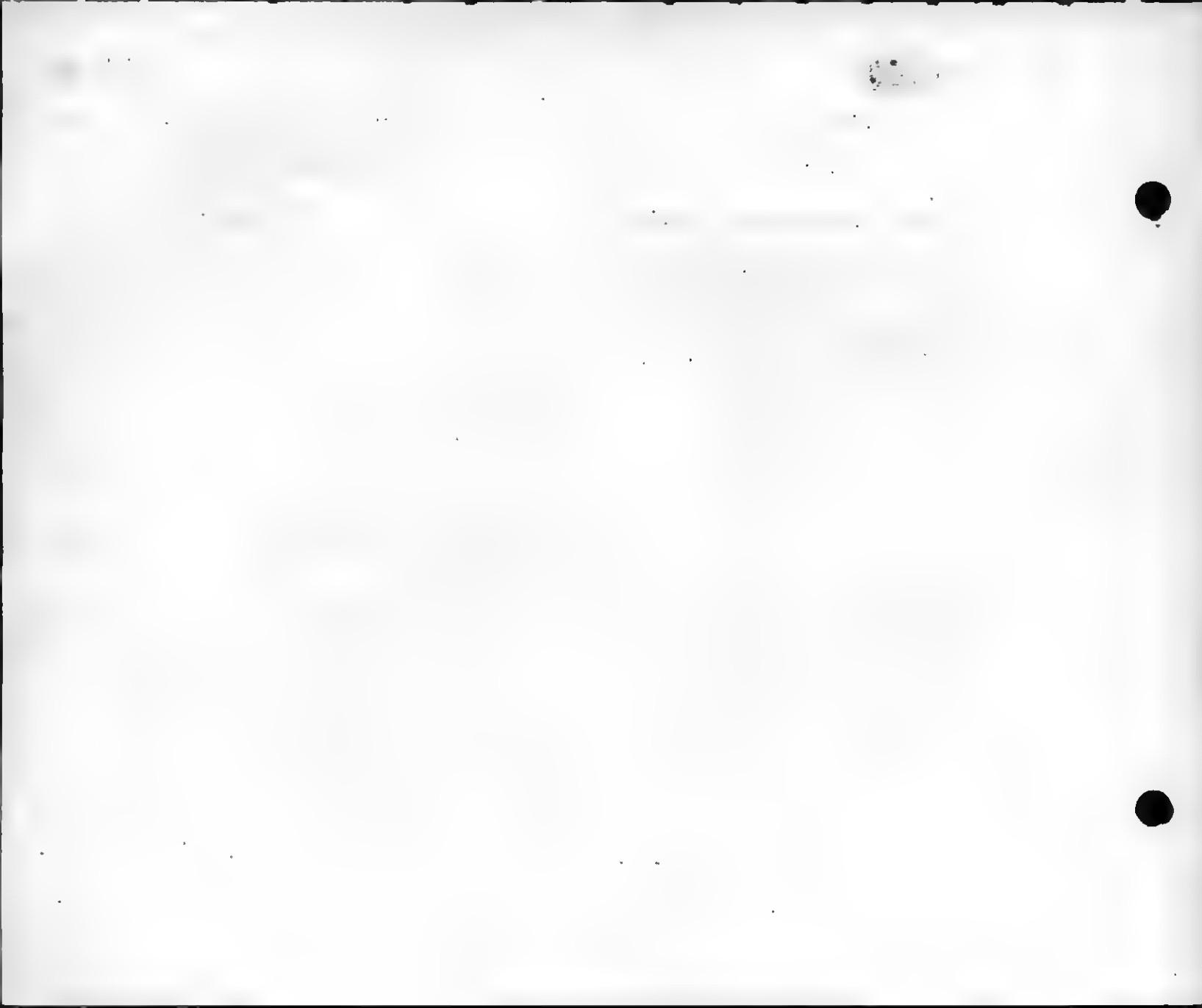
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04140

1. PLACE OF DEATH a. COUNTY <b>PrinceGeorges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince Georges</b>		
c. LENGTH OF STAY IN 1D <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PrinceGeorges General Hospital</b>		d. STREET ADDRESS <b>4107 51st Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Raymond</b>	Middle <b>EARL</b>	Last <b>Brown</b>	
4. DATE OF DEATH	Month <b>March</b>	Day <b>12</b>	Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-1889</b>	
9. AGE (In years last birthday) <b>77 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>CARPENTRY.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	13. FATHER'S NAME <b>UNKNOWN</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>217057201</b>	17. INFORMANT <b>CHARLOTTE I. BROWN</b>	Address <b>SAME AS #2</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF PROSTATE</b> 17. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CEREBRAL VASCULAR ACCIDENT</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-11-1966</b> to <b>3-12-1966</b> that (I) (we) last saw the deceased alive on <b>3-11-1966</b> and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>3/12/66</b>		
22a. SIGNATURE <i>Albert Rogh</i>	M.D. ATTENDING PHYS.	M.D. DIRECTOR	STAFF PHYS.	
22c. PHYSICIAN'S NAME (Type) <b>Albert Rogh, M.D.</b>	22d. ADDRESS <b>5409 Riverdale Rd., Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>15 MARCH 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>FT. LINCOLN CEMETERY</b>	23d. LOCATION (City, town or county) <b>BLADENSBURG, MARYLAND</b>	(State)
24. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>	ADDRESS <b>Riverdale, Md.</b>	25a. REC'D BY REGISTRAR <b>JAR 15 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

IN HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.



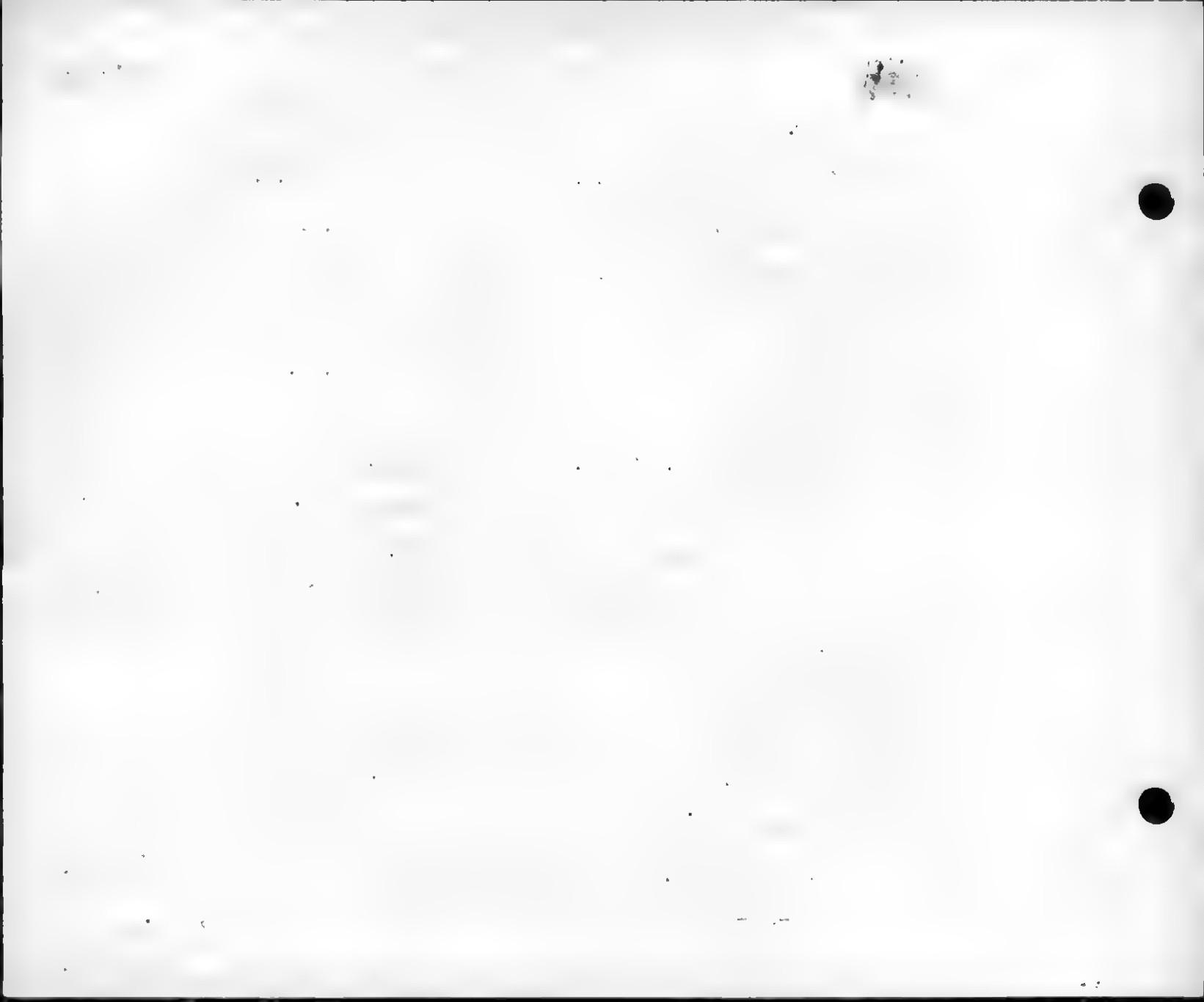
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**11 TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

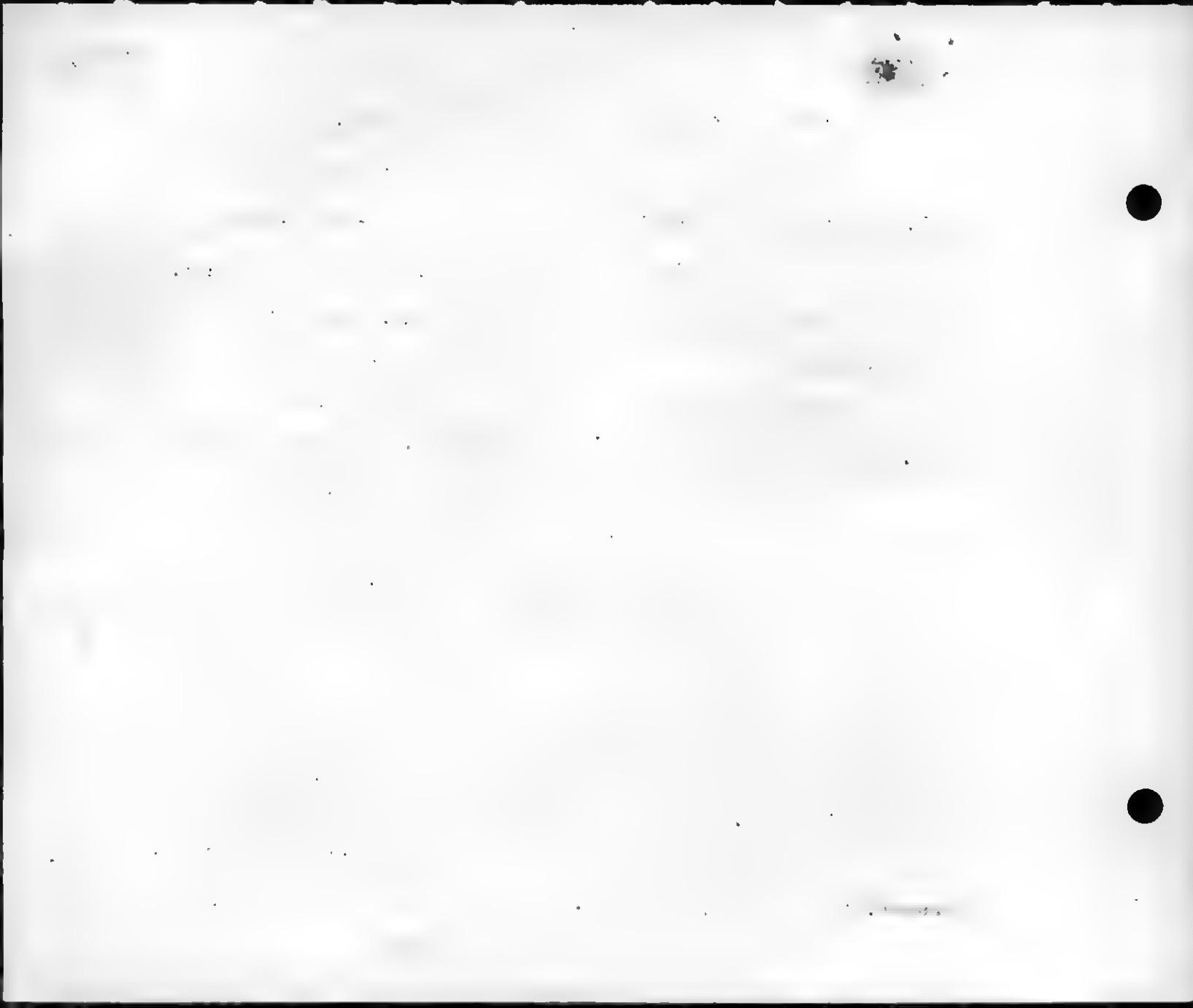
04150		04141	
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>3222 M St., S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James W. Browne</b>		First	Middle
4. DATE OF DEATH <b>March 12, 1966</b>		Month	Day Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1/14/1917</b>		9. AGE (in years last birthday) <b>49 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>
13. FATHER'S NAME <b>Wilson Browne</b>		14. MOTHER'S MAIDEN NAME <b>Annie Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-20-4125</b>	17. INFORMANT <b>decedent</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemorrhage into bronchial tree</b>		INTERVAL BETWEEN ONSET AND DEATH <b>90 min.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <b>1172</b>		6 mos.	
DUE TO <b>Metastatic carcinoma of neck</b>		1 year	
(c) <b>Carcinoma of floor of the mouth and right mandible</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary tuberculosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) <b>Landover</b> (County) <b>Md.</b> (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/10/1965</b> to <b>3/12/1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/12/1966</b> , and that death occurred at <b>5:25PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/12/66</b>
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL/CREMATION REMOVAL (Specify) <b>3-16-66</b>		23b. DATE THEREOF <b>3-16-66</b>	
23c. NAME OF CEMETERY OR CREMATORIALy <b>Harmony Memorial Park Landover, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Bellis 4339 Hunt Rd. E.</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>MAR 16 1956</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												04142			
CERTIFICATE OF DEATH												04151			
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Mass.</b> b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>14 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dorchester</b>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>3 Belton Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Frederic</b>	Middle	Last <b>Buckley</b>	4. DATE OF DEATH <b>Mar. 12 1966</b>	Month	Day	Year							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>26 Jan. 1919</b>	9. AGE (In years last birthday) <b>47 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles H Buckley</b>				14. MOTHER'S MAIDEN NAME <b>Helen M Baker</b>								Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>025 09 5336</b>				17. INFORMANT <b>Charles H. Buckley Jr Decatur Indiana</b>				INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nutritional Hepatic Cirrhosis - Ascites</b> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Eosophageal Varices</b> DUE TO (c) <b>Splenomegaly + Jaundice</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>3-12-66</b>		(County) <b>1966</b>		(State) <b>3-12-66</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3/12 1966</b> , and that death occurred at <b>5:30 AM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>D. Banisadr</b>				22b. DATE SIGNED <b>3-12-66</b>											
22c. PHYSICIAN'S NAME (Type) <b>A Banisadr</b>				22d. ADDRESS <b>Hospital staff Cheverly Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>				23b. DATE THEREOF <b>Mar 13, 1966</b>				23c. NAME OF CEMETERY OR CREMATORIAL <b>Mulry Funeral Home</b>				23d. LOCATION (City, town or county) (State) <b>Boston Massachusetts</b>			
24. FUNERAL DIRECTOR <b>J. Gasch's Sons Bryantville</b>				ADDRESS <b>DATE REC'D BY REGISTRAR</b>				25a. REC'D BY REGISTRAR <b>15 Mar 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Marley Judge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

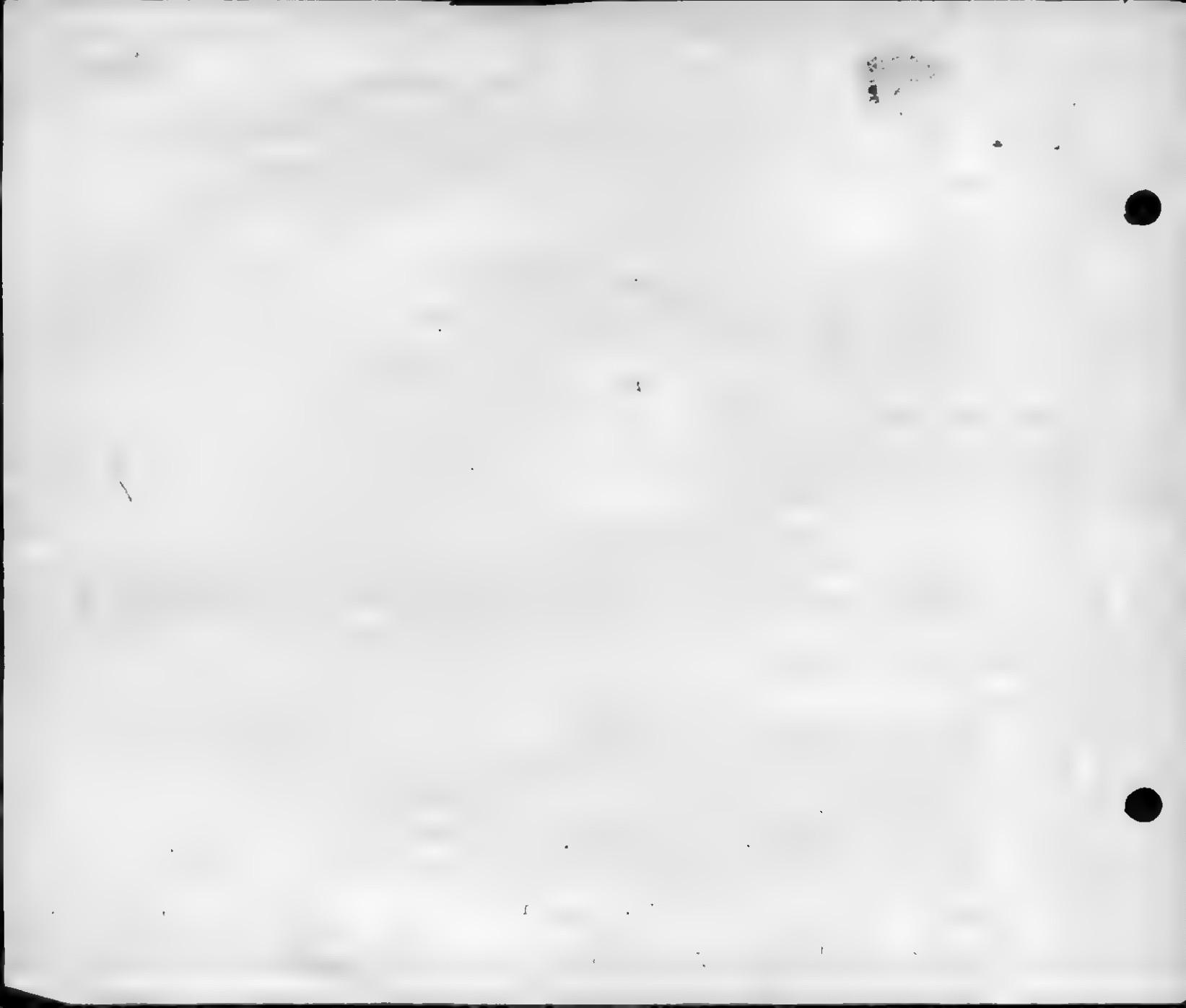
04150

04143

**NO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)</b>	
a. COUNTY <i>Prince Georges</i>		a. STATE <b>MD</b> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>EAST RIVERDALE</i>		c. LENGTH OF STAY IN 1b <i>15 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>DOA in AMBULANCE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF</b> <b>(Type or print)</b> <i>CARL</i>		First	Middle
		Last	<b>4. DATE OF DEATH</b>
			Month
			Day
			Year
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH
m		w	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 3/29/1910 9. AGE (in years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MAINTAINANCE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Briggs Co.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>SEAS PLEASANT MD USA</i>
13. FATHER'S NAME <i>Pedro BUTLER/BACIGALUPPI</i>		14. MOTHER'S MAIDEN NAME <i>Mabel Richardson</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> NO		16. SOCIAL SECURITY NO. <i>217 01 7996</i>	17. INFORMANT <i>WIFE</i> Address <i>same</i>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Cause last. } (c)		<i>Coronary Thrombosis, ACUTE Anterior Sclerotic Heart Disease</i> 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
p.m. 19		Nov 1963 to 3/28/66	
21 I certify that (I) (this hospital) attended the deceased from Nov 1963 to 3/28/66, that (I) (we) last saw the deceased alive on Feb 26 1966 and that death occurred at 10 AM from the causes and on the date stated above.			
22a. SIGNATURE <i>Norman J. Comeau</i>		22b. DATE SIGNED <i>3/28/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Norman J. Comeau</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>3503 Penny St, Mt Rainier MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF <i>4/1/66</i>	
		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Francis Gasch's Sons Hyattsville, Maryland</i>		23d. LOCATION (City, town or county) <i>Colmar Manor, Md.</i>	
		ADDRESS	
		25a. REC'D. BY REGISTRAR DATE <i>MAR 31 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**1** **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~return~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if an event, within 72 hours after death.

M

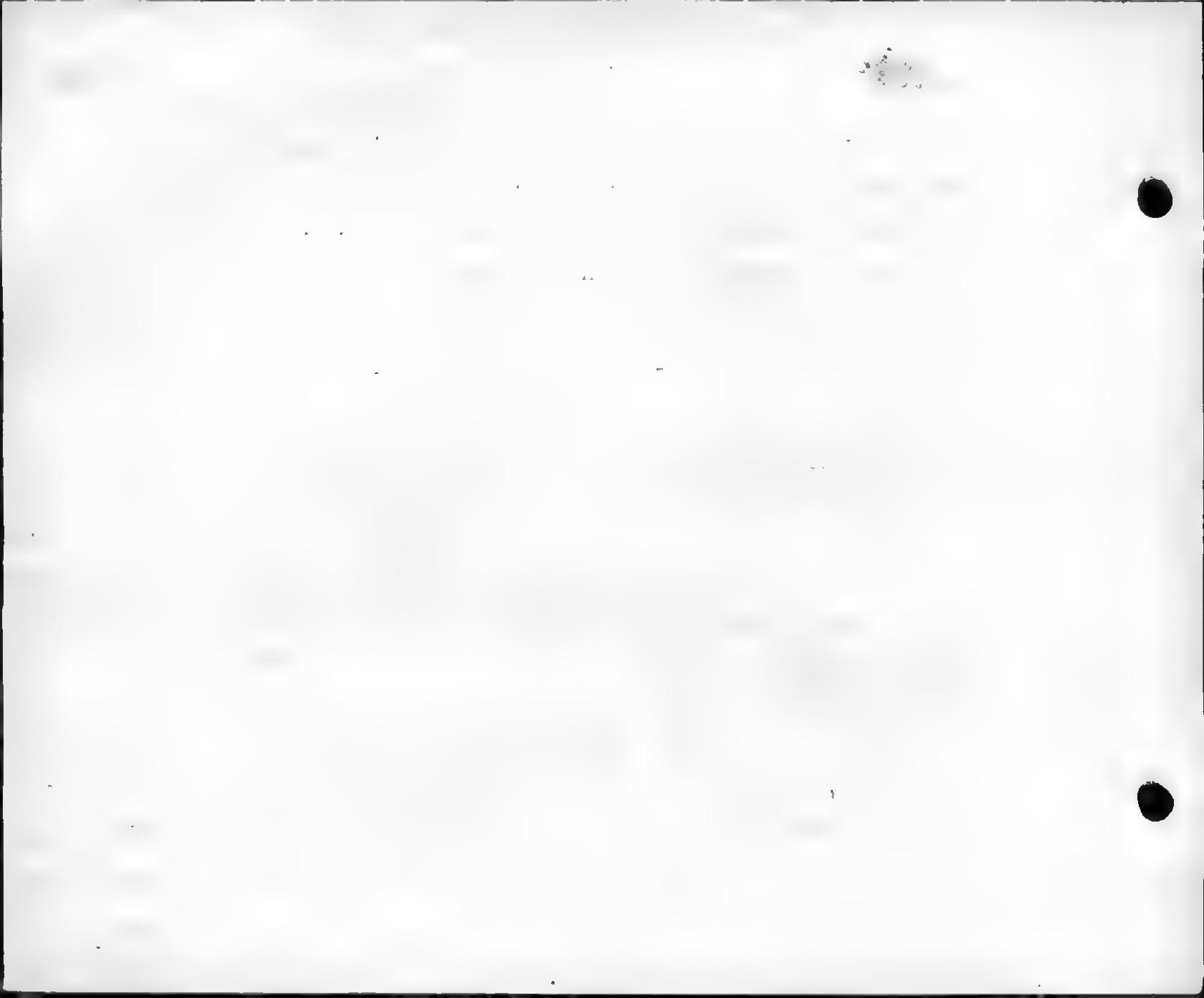
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04158

CERTIFICATE OF DEATH

04144

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>5 mos., 2 dys.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
f. STREET ADDRESS <b>1006 M St. N. W.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry</b>		First	Middle
		<b>H.</b>	<b>Butler</b>
4. DATE OF DEATH <b>March 6 1966</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7/3/1918</b>	9. AGE (In years last birthday) <b>47 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours
10a. USLAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Louisa Co., Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Henry Butler</b>		14. MOTHER'S MAIDEN NAME <b>Ida ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Decedent</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>(b)</b>		DUE TO <b>Probable myocardial infarction (clinical)</b>	
(c) stating the underlying cause <b>Pulmonary tuberculosis (7 mo.) and generalized arteriosclerosis</b>		DUE TO <b>(d)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus; chronic pyelonephritis; benign prostatic hyper trophy</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>
20f. (City or town) <b>---</b>		(County) <b>---</b>	
20g. (State) <b>---</b>			
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>10/4 1965</b> to <b>3/6 1966</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>3/6 1966</b> , and that death occurred at <b>150 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/6/66</b>
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital</b> <b>Glenn Dale, Maryland</b>	
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-12-1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>HARMONY</b>
23d. LOCATION (City or Town) <b>LANDOVER</b>		(County) <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>W.E. Jarvis</b>		ADDRESS <b>1432 - You St N.W.</b>	25a. REC'D BY REGISTRAR DATE <b>MAR 11 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from this form pages 1 and 2, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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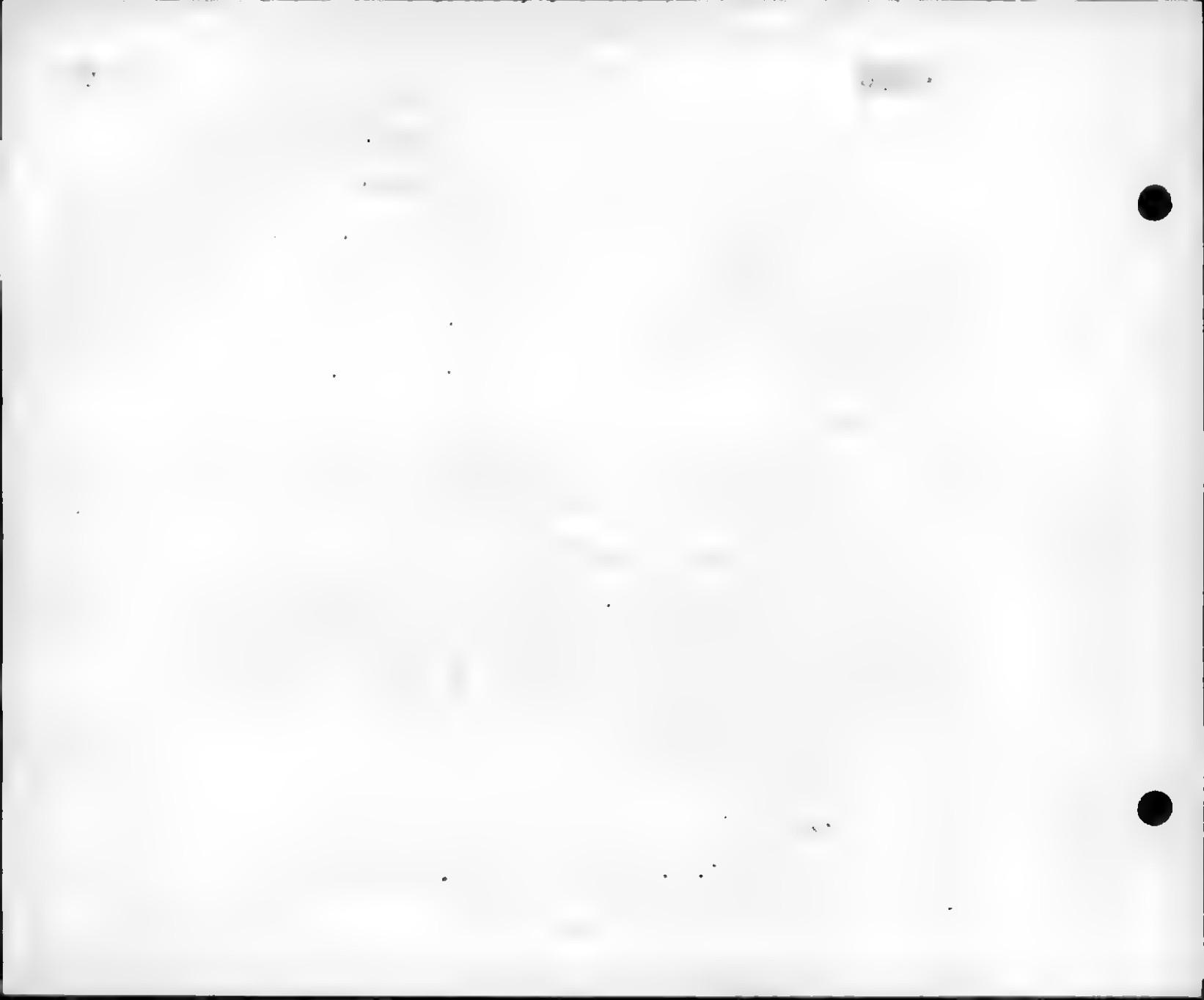
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03154

CERTIFICATE OF DEATH

03145

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Maggie</b>		First <b>Butler</b>	Middle <b></b>
4. DATE OF DEATH <b>March 9 1966</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>8/4/1898</b>	9. AGE (in years last birthday) <b>67 yrs</b>	F UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Thomas Kyles</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Belt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> <b>---</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Decedent</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cerebrovascular accident, right, probably thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
DUE TO (b) <b>Cerebral arteriosclerosis</b>		Unknown	
DUE TO (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Bronchopneumonia; arteriosclerotic heart disease; chronic pyelonephritis; osteoarthritis</b>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>2/11 6-20 PM, to 3/9 1966</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>3/9 1966</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED <b>3/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. (B)URIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/16/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <i>John T. Stewart Jr.</i>	ADDRESS <b>STEWART FUNERAL HOME 4001 BENNING RD.</b>	25a. REC'D BY REGISTRAR DATE <b>MAR 14 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04146

**TO HOSPITAL**  **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

04155

1. PLACE OF DEATH  
a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN 16

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Carroll Manor Nursing Home

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

WIDOWED  DIVORCED 

Dec. 6, 1880

9. AGE (in years  
last birthday)

85 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County &amp; State, or foreign country)

Washington D. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOCIAL SECURITY NO. 

(Yes, no, or unknown) (If yes, give rank and dates of service)

no

17. INFORMANT

James M. Campbell Same as #2 (son)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Cerebral thrombosis

Conditions, if any, which  
gave rise to immediate cause  
(e), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

Hypertension

Atherosclerotic heart disease

INTERVAL BETWEEN  
ONSET AND DEATH

2 years

10 years

10 years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.20d. INJURY OCCURRED  
While  
at work  Not While  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1-8-47 to 3-8-66, that (I) (we) last saw the deceased alive on 3-7-66, and that death occurred at p.m. from the causes and on the date stated above.

22e. SIGNATURE

22f. PHYSICIAN'S  
NAME (Type) John P. Clum, M. D.

M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22b. DATE  
SIGNED

3/8/66

22d. ADDRESS

6110 43rd Ave. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial23b. DATE THEREOF  
3/11/66

23c. NAME OF CEMETERY OR CREMATORIAL

Ft. Lincoln

23d. LOCATION (City, town or county)

(State)

Colmar Manor,

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

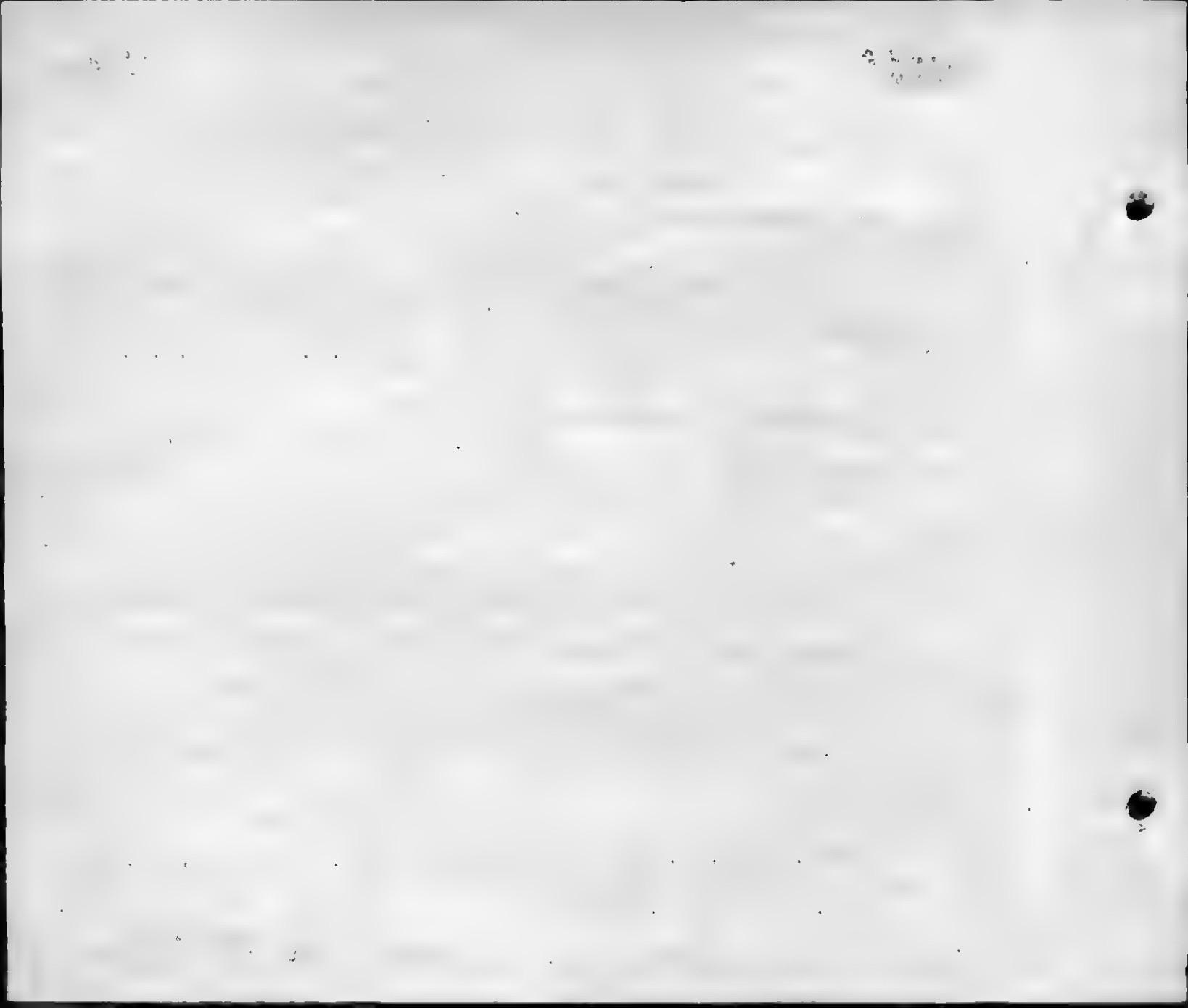
Francis Gasch's Sons Hyattsville, Md.

25e. REC'D BY REGISTRAR

MAR 10 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



Item 18 Film G375 3/3 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04156

## CERTIFICATE OF DEATH

04147

1. PLACE OF DEATH a. COUNTY <b>P.G.</b>		Item 2 Film G375 3/3 MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>P.G.</b> 1772.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>1 yr</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1772 Bowie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General</b>		d. STREET ADDRESS <b>Route #1, Box 50</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lena</b>	Middle <b>I.</b>	Last <b>Carroll</b>	4. DATE OF DEATH <b>3 15 66</b>	Month Day Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>1/1/1900</b>	9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Apartment House Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Long Island, New York</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>		17. INFORMANT Address <b>Mr. John R. Cheseldine - 2720 N. Wisc. Ave., N.W., DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>586X</b> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		<b>① Bilateral Bronchopneumonia.</b>		INTERVAL BETWEEN ONSET AND DEATH Terminal	
		<b>② Arteriosclerotic Heart with myocardial infarction - hypop disease op. Sparks:</b>		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>** from cholecystectomy</b>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Washington</b> (County) <b>D.C.</b> (State) <b>D.C.</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 15, 1966</b> to <b>March 16, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 16, 1966</b> , and that death occurred at <b>111 M</b> ; from the causes and on the date stated above.					
22a. SIGNATURE <b>William Braun</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.M. BRAUN, M.D.</b>		22d. ADDRESS <b>624 Central Ave, Capitol Hgt's</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-19-66</b>		23b. DATE THEREOF <b>3-19-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ROCK CREEK CEMETERY</b>	
23d. LOCATION (City, town or county) <b>WASHINGTON, D.C.</b>		(State)			
24. FUNERAL DIRECTOR <b>William M. Hysong</b>		ADDRESS <b>WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

M

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

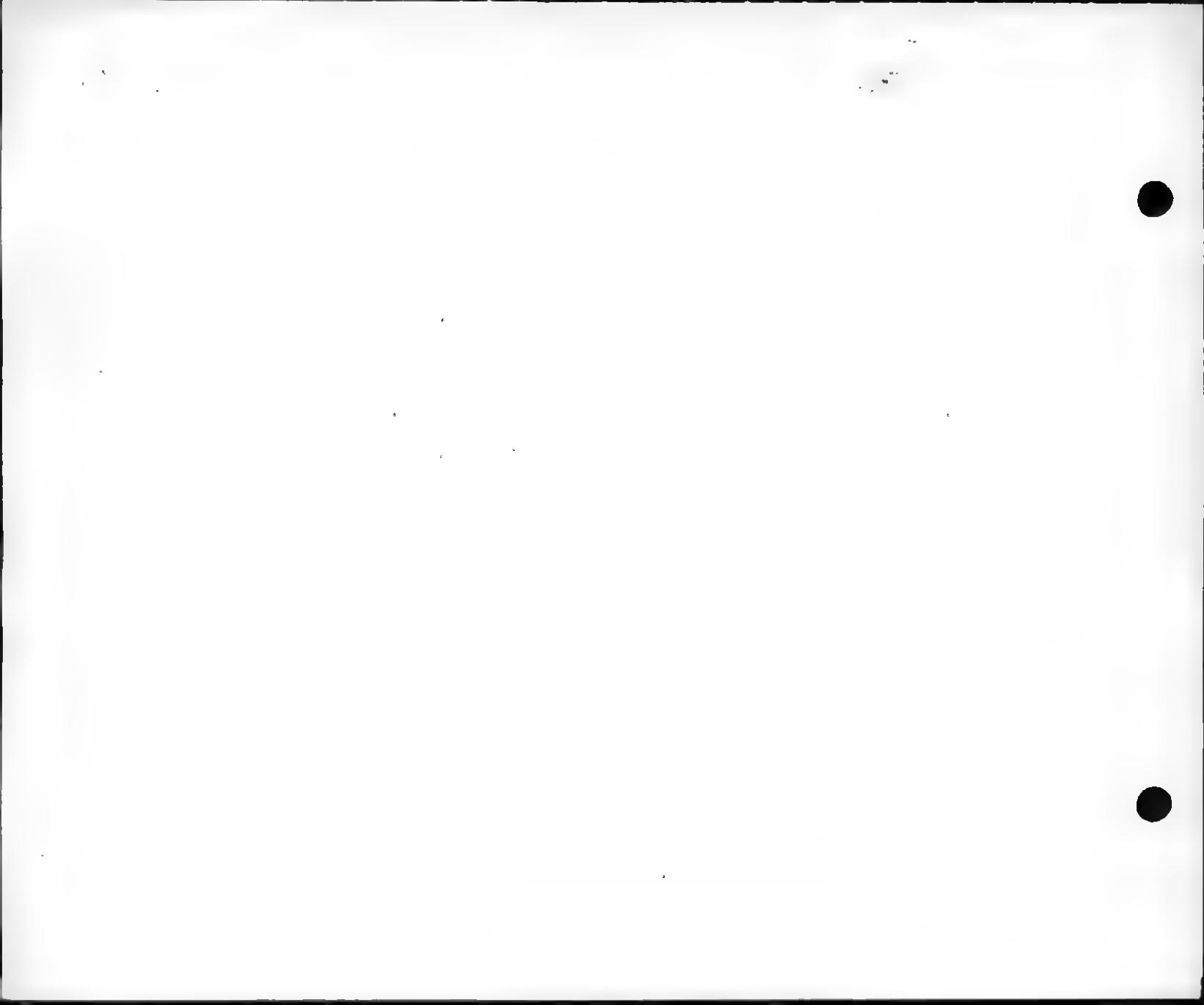
04148

04157

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial transit permit file pages 1, 2, and 3 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if not in an institution before admission) a. STATE New Jersey b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs	c. LENGTH OF STAY IN lb DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Saddlebrook				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrews Air Force Base Hospital		d. STREET ADDRESS 585 Fairlawn Parkway				
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) John Hubert Cole		4 DATE OF DEATH Month March Day 12 Year 1966				
S SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED	8 DATE OF BIRTH Sept. 28, 1923			
9 AGE (In years last birthday) 42 yrs		F UNDER 1 YEAR Months 1 Days 2 Hours 15 Min	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Exp diter	10b KIND OF BUSINESS OR INDUSTRY Bendix Aviation	11 BIRTHPLACE (State or foreign country) New Jersey	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME K. Herbert Cole		14 MOTHER'S MAIDEN NAME Helen Cole Nettie List				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Helen L. Cole		Address 585 Fairlawn Parkway
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO Arteriosclerotic heart disease		Occlusion of coronary artery		INTERVAL BETWEEN ONSET AND DEATH MINUTES		
(c) DUE TO				unknown		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rivendale	(County) N.J.	(State) New Jersey
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John Kehoe</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John Kehoe, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3-15-66	23c NAME OF CEMETERY OR CREMATORIUM Cedar Lawn Cemetery	23d LOCATION (City or Town) Patterson	(County) New Jersey	(State)
24 FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Rd Suitland Maryland		25a REC'D BY REGISTRAR MAR 15 1966	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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FOR STATE M  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04158

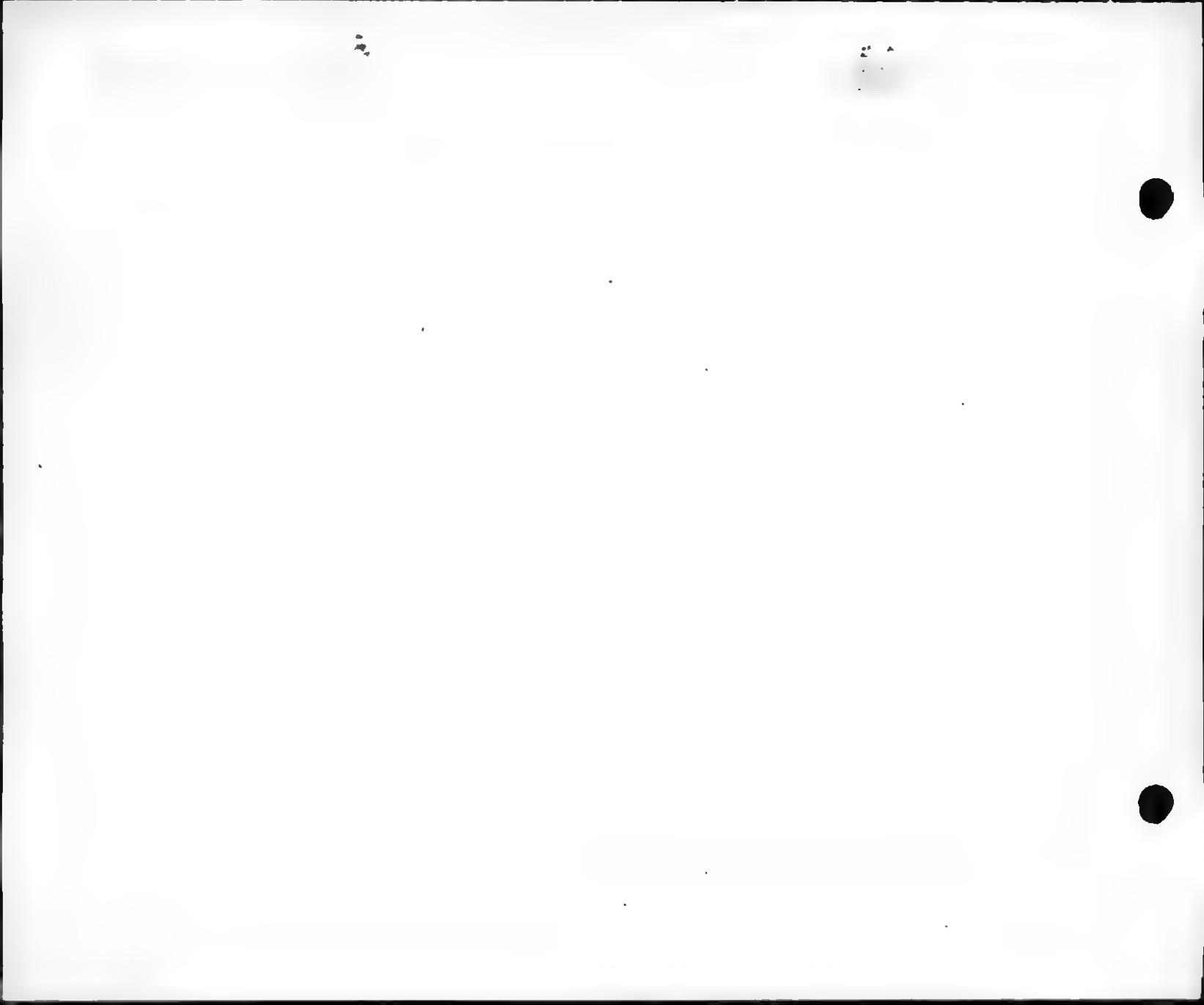
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04149

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ohio</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DCA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cuyahoga Falls</b>		d. STREET ADDRESS <b>2011 Lynd street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	Fist <b>Carmela</b>	Middle <b>D.</b>	Last <b>Coscia</b>	4. DATE OF DEATH <b>3 22 19 66</b>	Month Year	Month Year	Day Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Dec. 1882</b>	9. AGE (In years lost birthday) <b>83 yrs</b>	FUNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MICHAEL DE FEO</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINA MUSCARELLO</b>		Address <b>STELLA C. COSCIA 36 MARYLAND DR. RIVERDALE MD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIA. SECURITY NO <b>None</b>		17. INFORMANT <b>STELLA C. COSCIA</b>		INTERVAL BETWEEN ONSET AND DEATH minutes	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>		4100 Cardiovasc, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Arteriosclerotic heart disease		unknown	
DUE TO  DUE TO  (c)							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  <i>John Kehoe</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>3-22-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <b>3-22-66</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-26-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Cross</b>		23d. LOCATION (City or Town) (County) (State) <b>AKRON OHIO</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co 517 111 St S.E</b>		ADDRESS <b>W.W. Chambers Co 517 111 St S.E</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



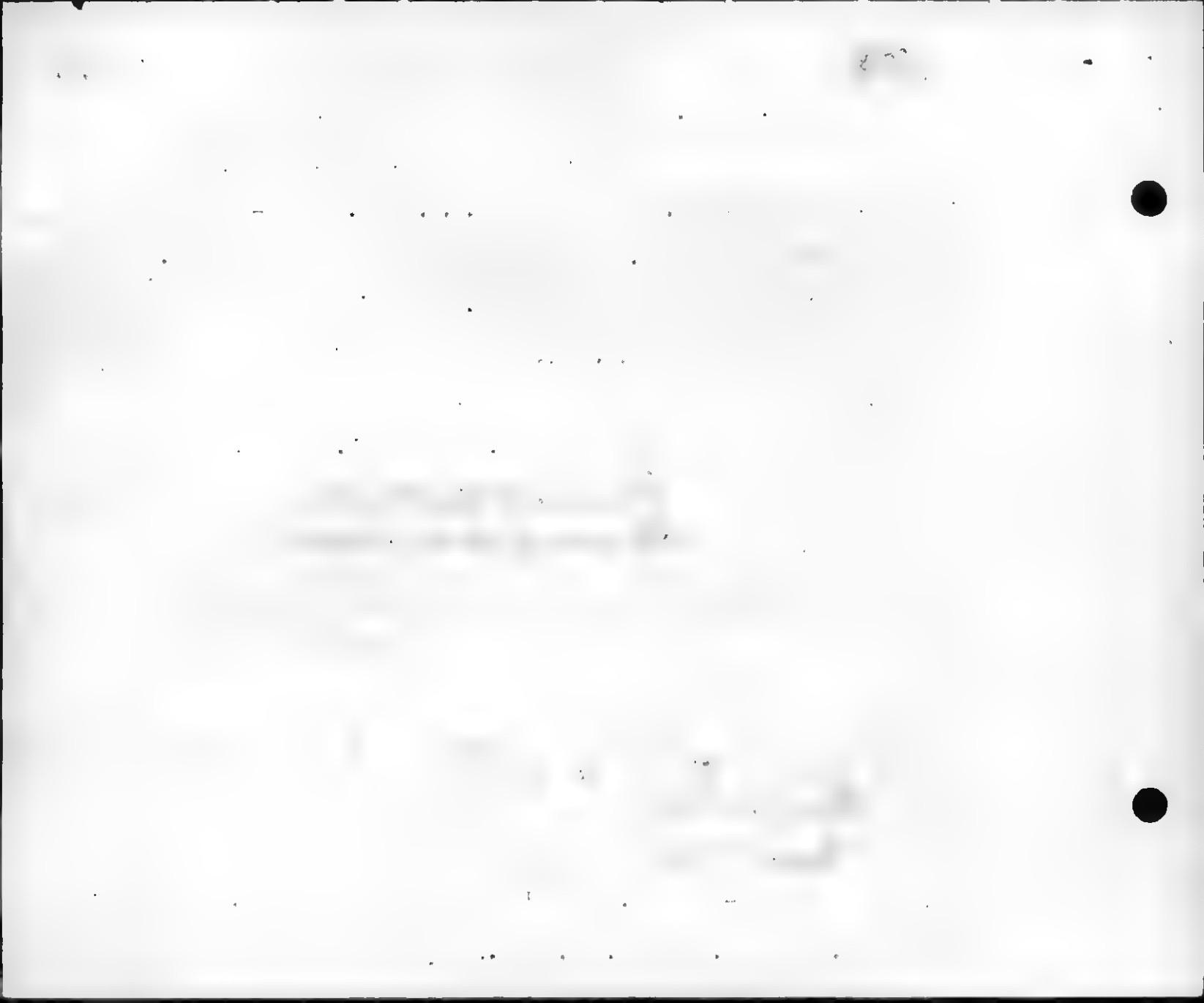
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers, Pages 1 and 2, to the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04159 04150

1. PLACE OF DEATH a. COUNTY Prince George's Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland	c. LENGTH OF STAY IN 1D 17- Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Nursing Home, Inc.				
3. NAME OF DECEASED (Type or print) ROSE	First T.	Middle .	Last COUNTY	
4. DATE OF DEATH March 19th, 1966	Month 19	Day Year 66	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4th 1884	
9. AGE (in years last birthday) 81 yrs.	10. UNDERTAKER FUNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Clerk U.S. Gov.	11. BIRTHPLACE (County & State, or foreign country) New Hampshire	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Rustler	14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Madeleine U. Pierce Same as Item # 2	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH Today				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3/10</i> , 1966, to <i>3/19</i> , 1966, that (I) (we) last saw the deceased alive on <i>3/15</i> 1966, and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED <i>3/21/66</i>		
22a. SIGNATURE <i>Thomas E. Cullen</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS	
22c. PHYSICIAN'S NAME (Type) <i>Thomas E. Cullen</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 23-66	23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cemetery	23d. LOCATION (City, town or county) (State) Manchester, New Hampshire
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS Simmons Bros. 1661- Gd. Hope Rd. SE. Wash. DC	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04160

04151

**TO HOSPITAL OR ATTENDING PHYSICIAN:** This certificate must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
1. PLACE OF DEATH  
a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Laurel

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

801 Main Street

First

Middle

3. NAME OF  
DECEASED  
(Type or print)

ALBERT GALLATIN CRAIG

5. SEX

6. COLOR OR RACE

7. MARRIED

WIDOWED

DIVORCED

NEVER MARRIED

DATE OF BIRTH

Aug 5 1893

72 yrs

Last

Month

Day

Year

4. DATE  
OF  
DEATH

March 10

1966

e. IS RESIDENCE  
ON A FARM?  
YES  NO 

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

(If yes, give who or what service)

electronic engineer F. C. C.

10b. KIND OF BUSINESS OR INDUSTRY

F. C. C.

11. BIRTHPLACE (County &amp; State, or foreign country)

Maryville Missouri

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

(If yes, give who or what service)

Albert Gallatin Craig

16. SOCIAL SECURITY NO.

119-05-6344

Address 801 Henry St

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give who or what service)

(If yes, give who or what service)

WWI

17. INFORMANT

Frances R Craig Laurel Md

INTERVAL BETWEEN  
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

give rise to immediate cause

(a), stating the underlying

cause last.

{ (b)

DUE TO

Conditions, if any, which

give rise to immediate cause

(b), stating the underlying

cause last.

{ (c)

Frances R Craig Laurel Md

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

p.m.

19

20d. INJURY OCCURRED

While at work

Not While at work

at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (the hospital) attended the deceased from

saw the deceased alive on

and that death occurred at

from the causes and on the date stated above.

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22a. SIGNATURE

Katherine Wray

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

March 10, 1966

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

**04161**

**04152**

1. PLACE OF DEATH  
a. COUNTY

Prince Georges

b. CITY OR TOWN (if outside corporate limits,  
write RURAL and give nearest town)

Upper Marlboro

c. LENGTH OF STAY IN 1b

MARYLAND

Transient

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

4108 Pratt Street

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

B.

Last

Crandell

4. DATE  
OF  
DEATH

Month  
3

Day  
Year

1966

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

10/23/25

9. AGE (in years  
last birthday)

40 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done ~~employed~~ ~~in~~ life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY / 11. BIRTHPLACE (County & State, or foreign country)

Gen. Construction

Maryland

13. FATHER'S NAME

Nelson R. Crandell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

14. MOTHER'S MAIDEN NAME

Pearl Sherbert

Address

Same as

Item #2.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Acute Myocardial Infarction

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 20d. INJURY OCCURRED  
p.m. 19 While Not While  
of work  at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10/1/1962 to 3/1/1966, that (I) (we) last saw the deceased alive on 3/1/1966, and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE

W. Clark Holmes

22b. DATE  
SIGNED

22c. PHYSICIAN'S  
NAME (Type)

A. Clark Holmes, M.D.

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22d. ADDRESS

3/1/66

23a. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (Specify)

Burial 3/4/66

23c. NAME OF CEMETERY OR CREMATORI

ADDRESS

Mt. Zion Cemetery

23d. LOCATION (City, town or county)

(State)

Lothian

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

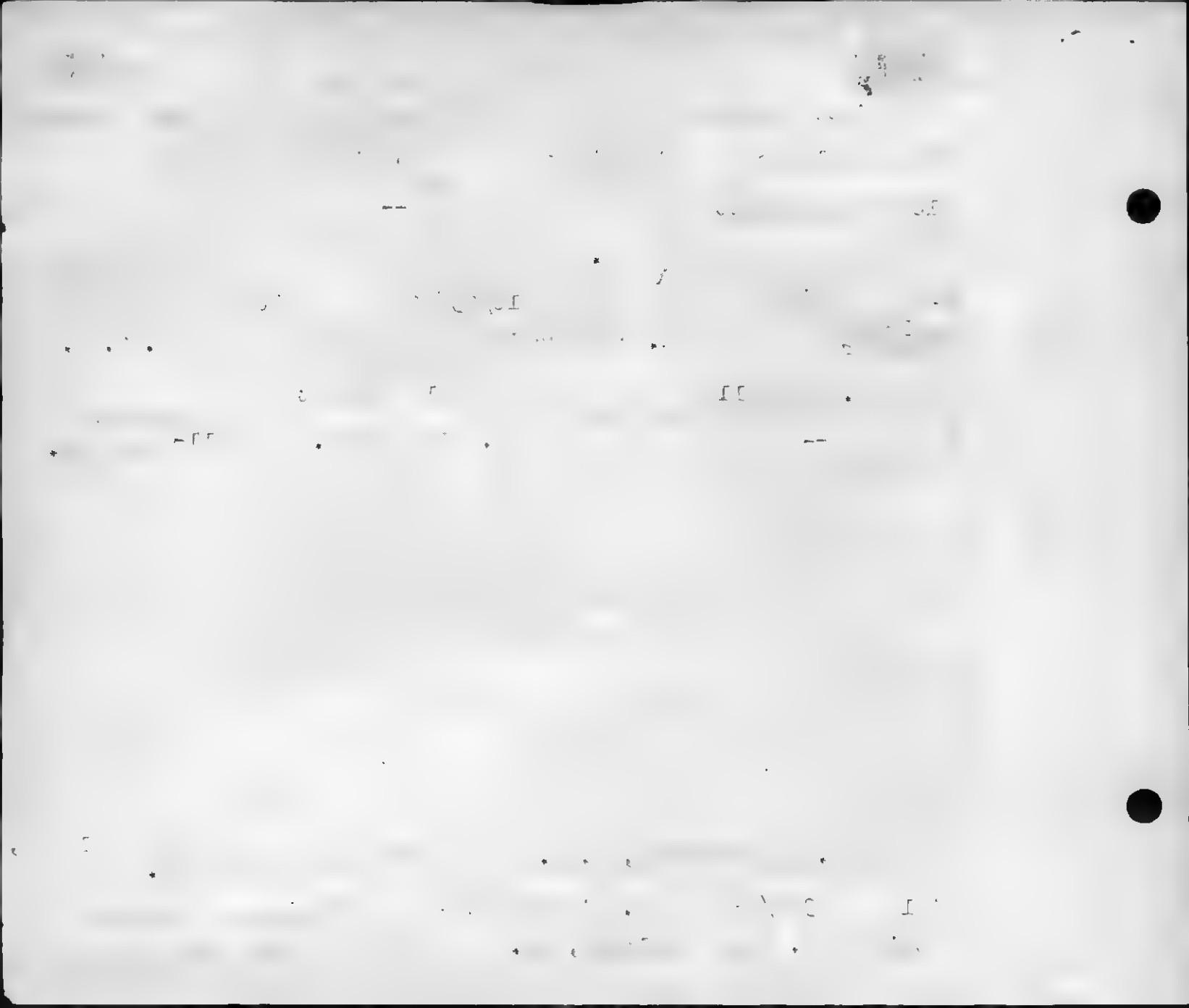
Ritchie Bros. Upper Marlboro, Md.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAR 7 1966

J Charles Judge



**HOSPITAL ATTENDING**: The law requires that the death certificate be presented within 24 hours after death.

**FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04162

Item 9

CERTIFICATE OF DEATH

04153

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Lanham

c. LENGTH OF STAY IN 1b

6 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Magnolia Garden Nursing Home

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month Day Year

KATHERINA

E.

CRILLY

March 19 19 66

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Jan. 4 1906

9. AGE (in years  
last birthday)

6660 yrs.

10. IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk Typist

10b. KIND OF BUSINESS OR INDUSTRY

Dept. of Agg.

11. BIRTHPLACE (County & State, or foreign country)

Penn.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Crilly

14. MOTHER'S MAIDEN NAME

Katherina Mc Garity

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-07-2331

17. INFORMANT

Address 4805 Rittenhouse

Miss Beatrice D. Throne

Riverdale

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO  
Conditions, If any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

cause (a), stating the  
underlying cause last.

(c)

pressure

malabsorbtion

paroxysm

INTERVAL BETWEEN  
ONSET AND DEATH

today

months

years

time

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)  
20d. INJURY OCCURRED While Not White  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.) 20f. (City or town)  
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/16/66 to 3/19/66, to 1966, that (I) (we) last saw the deceased alive on 3/16/66, and that death occurred at 11:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

*John R. Levitsky*

22b. DATE SIGNED

3-19-66

22c. PHYSICIAN'S  
NAME (Type)

LEON R. LEVITSKY

M.O. ATTENDING  
PHYS.

MEG.

DIRECTOR

STAFF

PHYS.

22d. ADDRESS

3408 Rhode Island Av. Mt. Rainier

23a. BURIAL, CREMATION  
REMOVAL (Specify)

Burial 3-22-66

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

Washington, D.C.

24. FUNERAL DIRECTOR

W.W. CHAMBERS Co

ADDRESS

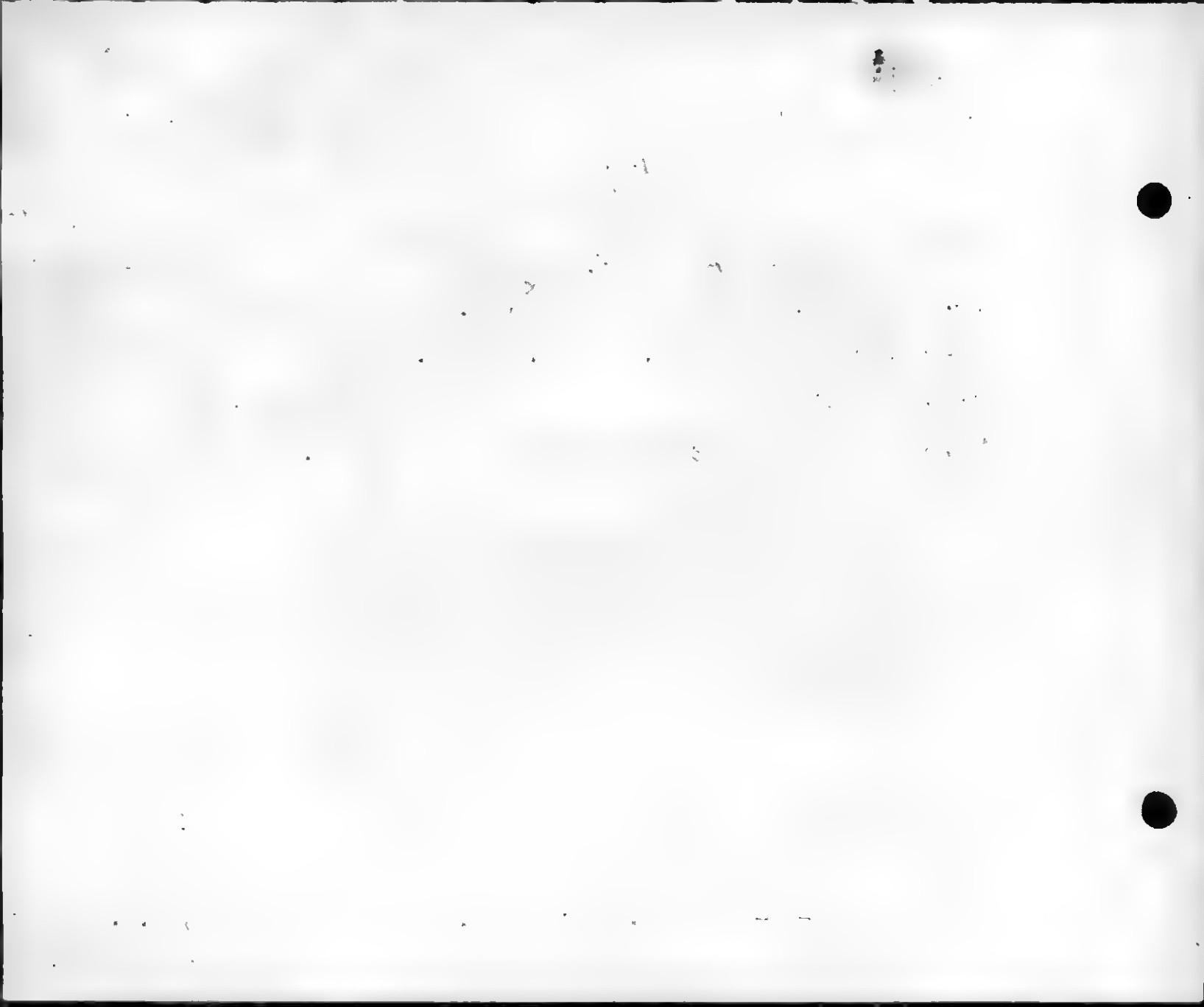
RIVERDALE MD.

25a. REC'D BY REGISTRAR

DATE MAR 23 1966

25b. REGISTRAR'S SIGNATURE

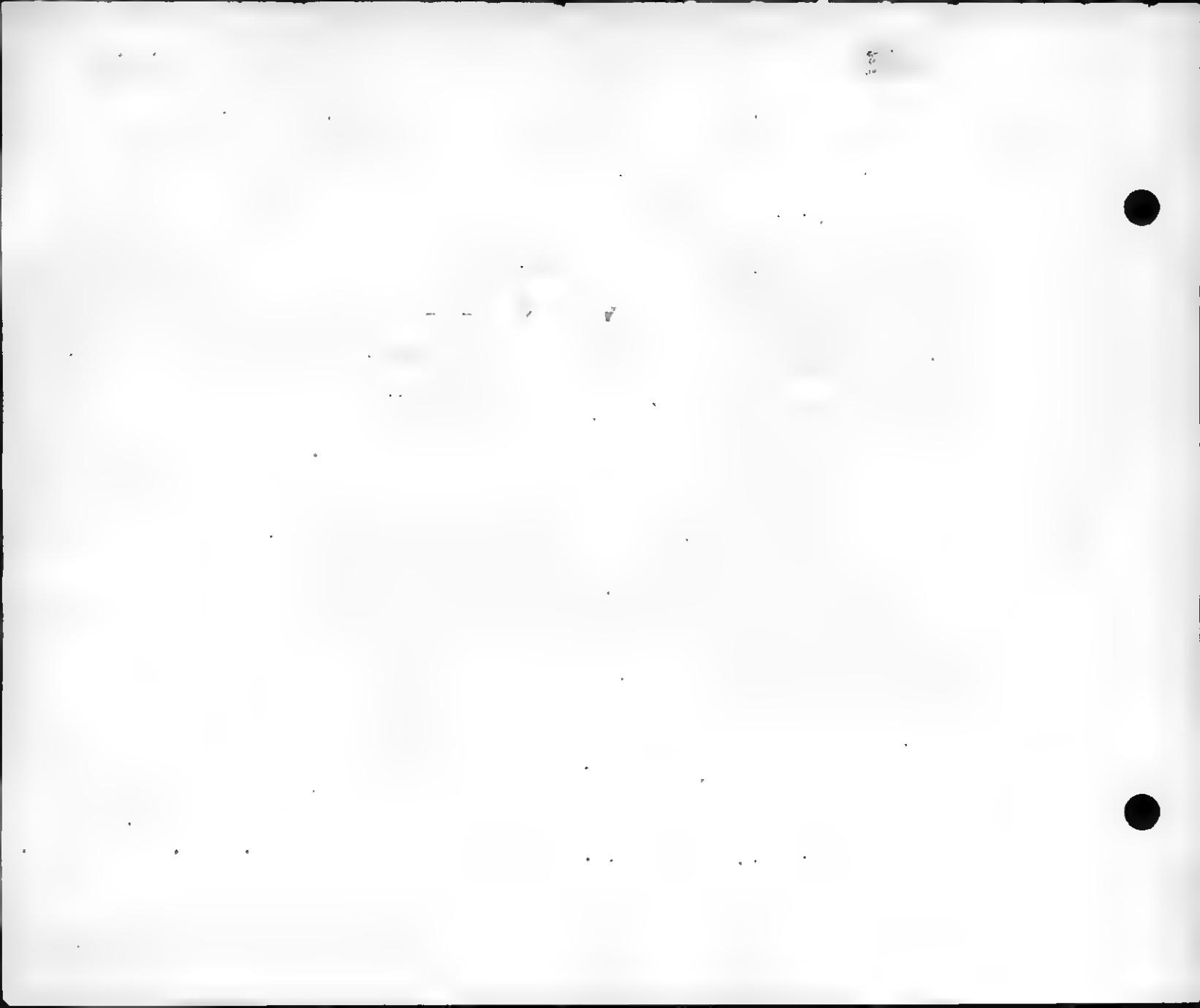
*Charles Judge*



TO HOSPITAL OR TREATING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

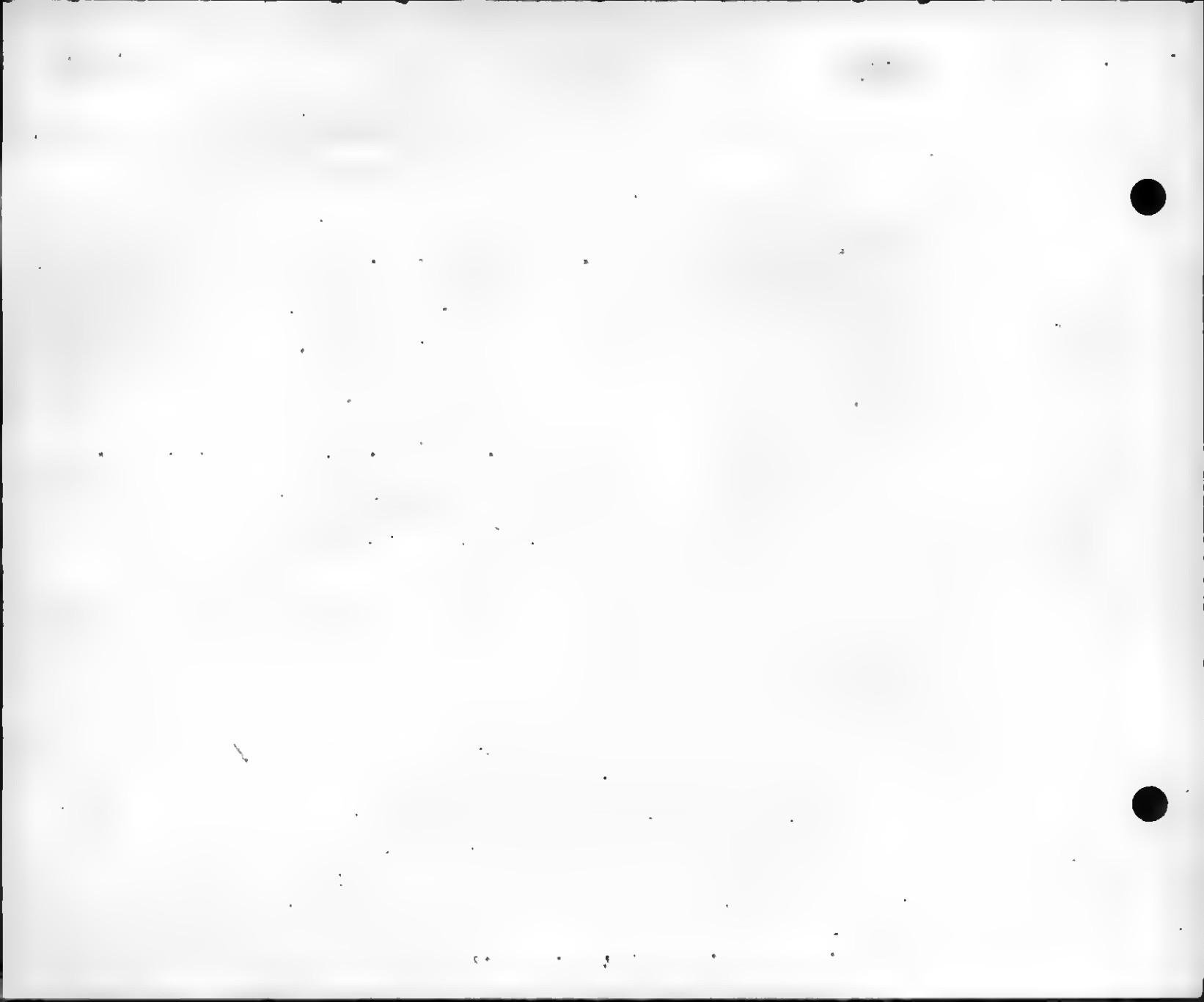
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY PG							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> 8 days				c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General</b>				d. STREET ADDRESS <b>5015 Olympia Avenue</b>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)	First <b>Agnes</b>	Middle <b>Cullen</b>	Last	4. DATE OF DEATH 3 30 1966	Month	Day	Year				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-24-98</b>	9. AGE (in years last birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>name</b>			11. BIRTHPLACE (County & State, or foreign country) <b>No location co</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Millard Filmore</b>				14. MOTHER'S MAIDEN NAME <b>Hackley</b>				Ann Riley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.				17. INFORMANT			
Address <b>Hospital Records.</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse peritonitis and septicemia</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>due to perforated Duodenal ulcer.</b> DUE TO (c) <b>ulcer.</b>											
INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>March 22, 1966</b> , to <b>March 30, 1966</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>March 30, 1966</b> , and that death occurred <b>at 3:30 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Edwin J. Jensen</b>											
22b. DATE SIGNED <b>3/31/66</b>											
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>				22d. ADDRESS <b>prince George's Genl. Hosp. Cheverly Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burn</b>		23b. DATE THEREOF <b>4-4-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lorraine Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>					
24. FUNERAL DIRECTOR <b>DeWitt Danaedan, Laurel, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
VR A15 (4) 20M 1/65											



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Prince George</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>				3. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leaven, MD</i>					
c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leaven, MD</i>				d. STREET ADDRESS <i>7121 Leaven Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Richard</i>	Middle <i>E.</i>	Last <i>Darnall, SR.</i>	4. DATE OF DEATH Month <i>Sept</i> Day <i>26</i> Year <i>1966</i>	Month <i>Sept</i>	Day <i>26</i>	Year <i>1966</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 26th 1911</i>	9. AGE (in years last birthday) <i>55 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Policeman</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Washington, DC.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Policeman</i>		14. MOTHER'S MAIDEN NAME <i>Florence G. Wallingsford</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>Mrs. Jessie B. Darnall</i>		17. INFORMANT <i>S. No. as #2.</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Auto pulmonary edema</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchogenic carcinoma</i> DUE TO (c) <i>Cancer</i>										INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Suitland, Maryland</i>		(County) <i>Mt. Rainier, Md.</i>		(State) <i>Md.</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>62</i> to <i>3/1/66</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3/1/66</i> , and that death occurred at <i>~:~ M.</i> from the causes and on the date stated above.													
22a. SIGNATURE <i>Norman B. Omeare</i>												22b. DATE SIGNED <i>3/1/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Norman B. Omeare</i>		22d. ADDRESS <i>3503 Long St. Mt. Rainier, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 4, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) <i>Suitland, Maryland</i>		(State) <i>Md.</i>					
24. FUNERAL DIRECTOR <i>Simons Bros.</i>		ADDRESS <i>1661-Gd. Hope Rd. SE. Wash., DC</i>		25a. REGD BY REGISTRAR <i>110-3-1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles B. Omeare</i>							



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

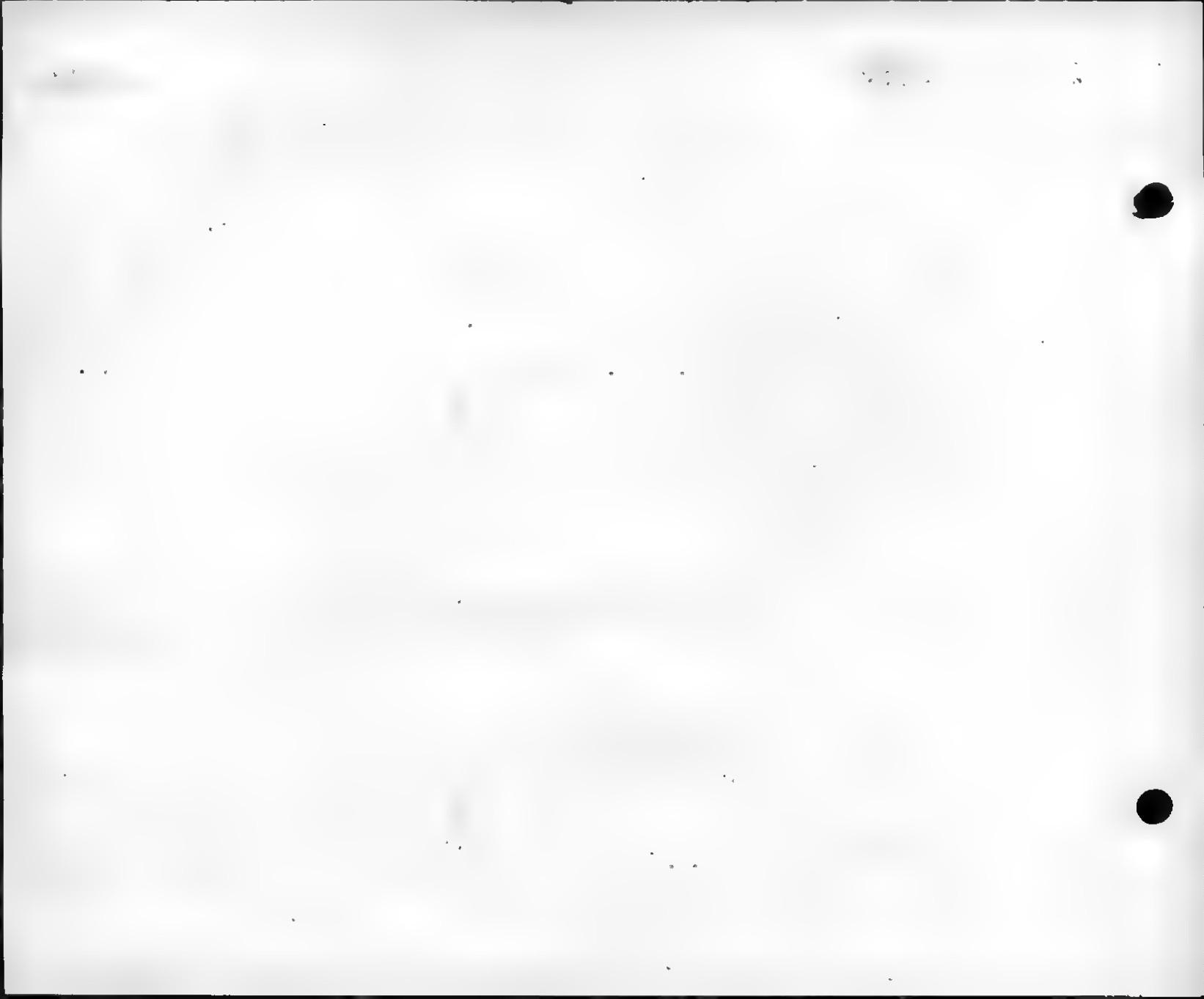
## CERTIFICATE OF DEATH

04165

04156

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

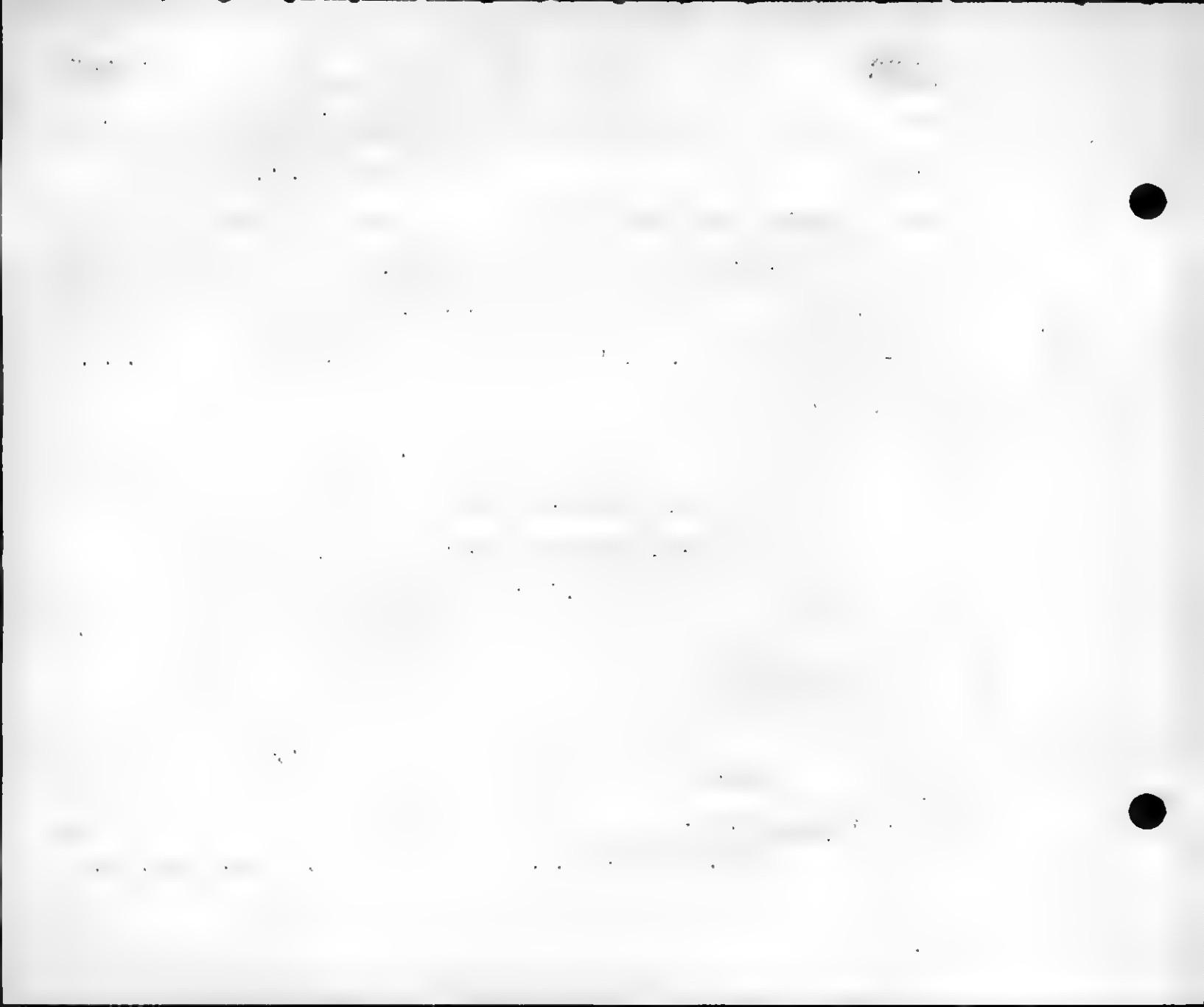
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Glenn Dale)</b>		c. LENGTH OF STAY IN b. <b>10 years, 7 mo.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		f. STREET ADDRESS <b>2820 Pennsylvania Ave., S.E.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Virginia</b>		First	Middle	Last	4. DATE OF DEATH <b>March 20 1966</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1924</b>	9. AGE (In years last birthday) <b>41 yrs.</b>	IF UNDER 1 YEAR Months <input type="checkbox"/>	IF UNDER 24 HS Days <input type="checkbox"/>	Hours <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Dept. Agriculture</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Thomas, West Virginia U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Sante DelSignore</b>		14. MOTHER'S MAIDEN NAME <b>Lucia Centofanti</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Person</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
121 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO stating the underlying cause lost. (c) <b>Pulmonary tuberculosis, far advanced</b>						16 years, 5 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20. MEDICAL CERTIFICATION <b>Cor pulmonale</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <b>Glenn Dale</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 29, 1955</b> , to <b>March 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 20 1966</b> , and that death occurred at <b>1:05 P.M.</b> , from causes and on the date stated above.									
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>March 20, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Maryland</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>3-23-1966</b>		23b. DATE THEREOF <b>3-23-1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Calvary Cemetery</b>		23d. LOCATION (City or Town) <b>Fairfax</b>		(County) (State) <b>Va.</b>	
24. FUNERAL DIRECTOR <b>Falls Church Funeral Home</b> <b>1102 W. Broad St. Falls Church, Va.</b>						25a. REC'D BY REGISTRAR <b>CHARLES JUDGE</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**1** **HOSPITAL OR ATTENDING PHYSICIAN:** Th law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, it may be retained by the hospital or attending physician. Then please have carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2, director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			04157		
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb --				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital (DOA)				d. STREET ADDRESS 501 Cabin Branch Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First George	Middle W	Last Dickens	4. DATE OF DEATH March 1 1966	Month March	Day 1	Year 1966									
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1910	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Census Bureau			10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			11. BIRTHPLACE (County & State, or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Eddie B. Dickens			14. MOTHER'S MAIDEN NAME Lena Arrington														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. WWII		17. INFORMANT Margaret L. Dickens		Address 501 Cabin Branch Road											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema												INTERVAL BETWEEN ONSET AND DEATH					
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Coronary occlusion (left circumflex coronary) (c) Coronary arteriosclerotic																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 3-2, 1966, to March 1, 1966, that (I) (we) last saw the deceased alive on March 1, 1966, and that death occurred at M, from the causes and on the date stated above.																	
22a. SIGNATURE <i>George J. Hageague</i>				22b. DATE SIGNED 3-1-66													
22c. PHYSICIAN'S NAME (Type) George J. Hageague, M.D.				22d. ADDRESS 3717 38th Ave. Cottage City, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-4-66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National				23d. LOCATION (City, town or county) Arlington				(State) Virginia					
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Rd Suitland Maryland		25a. REC'D BY REGISTRAR MAR 3 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

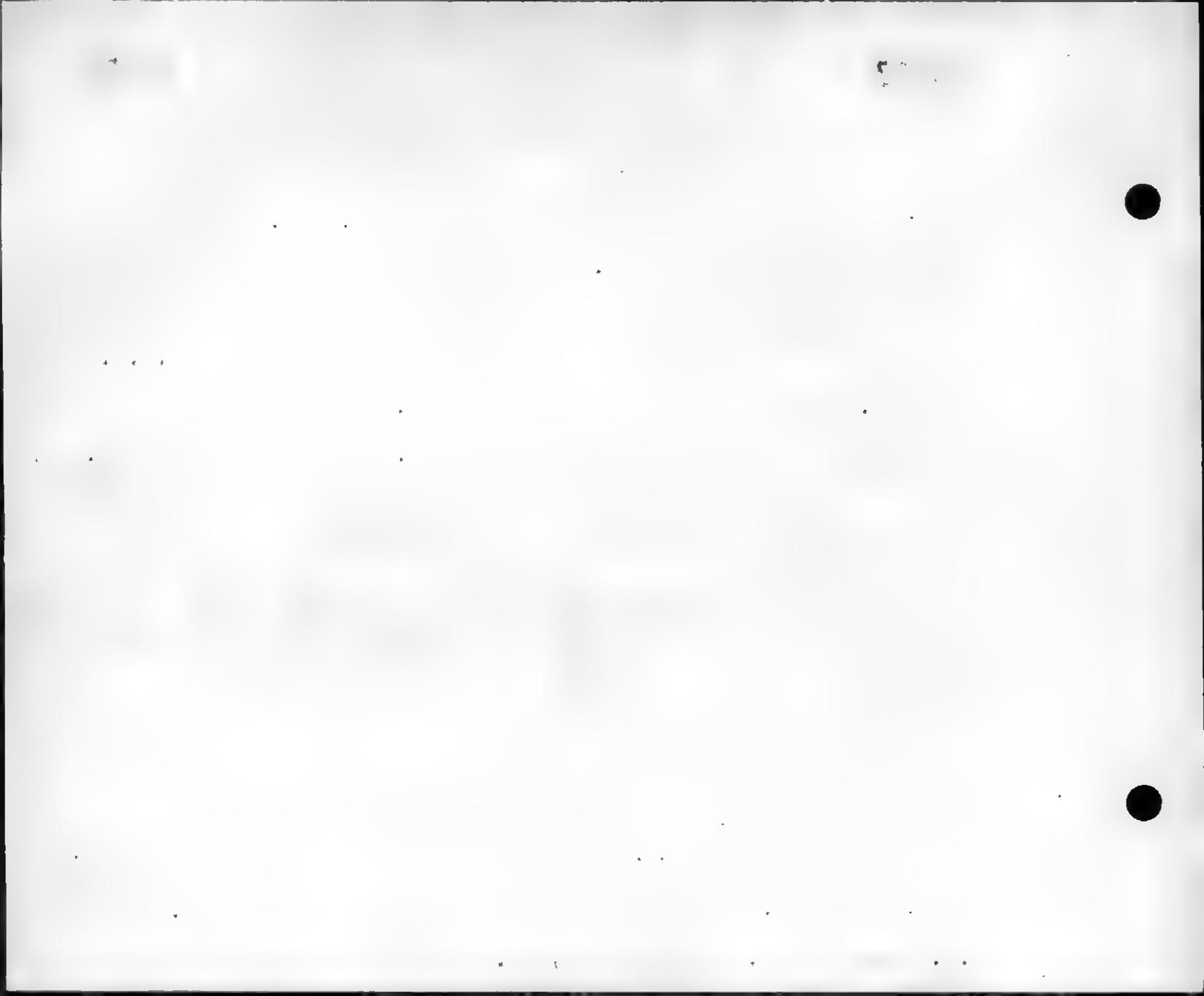
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

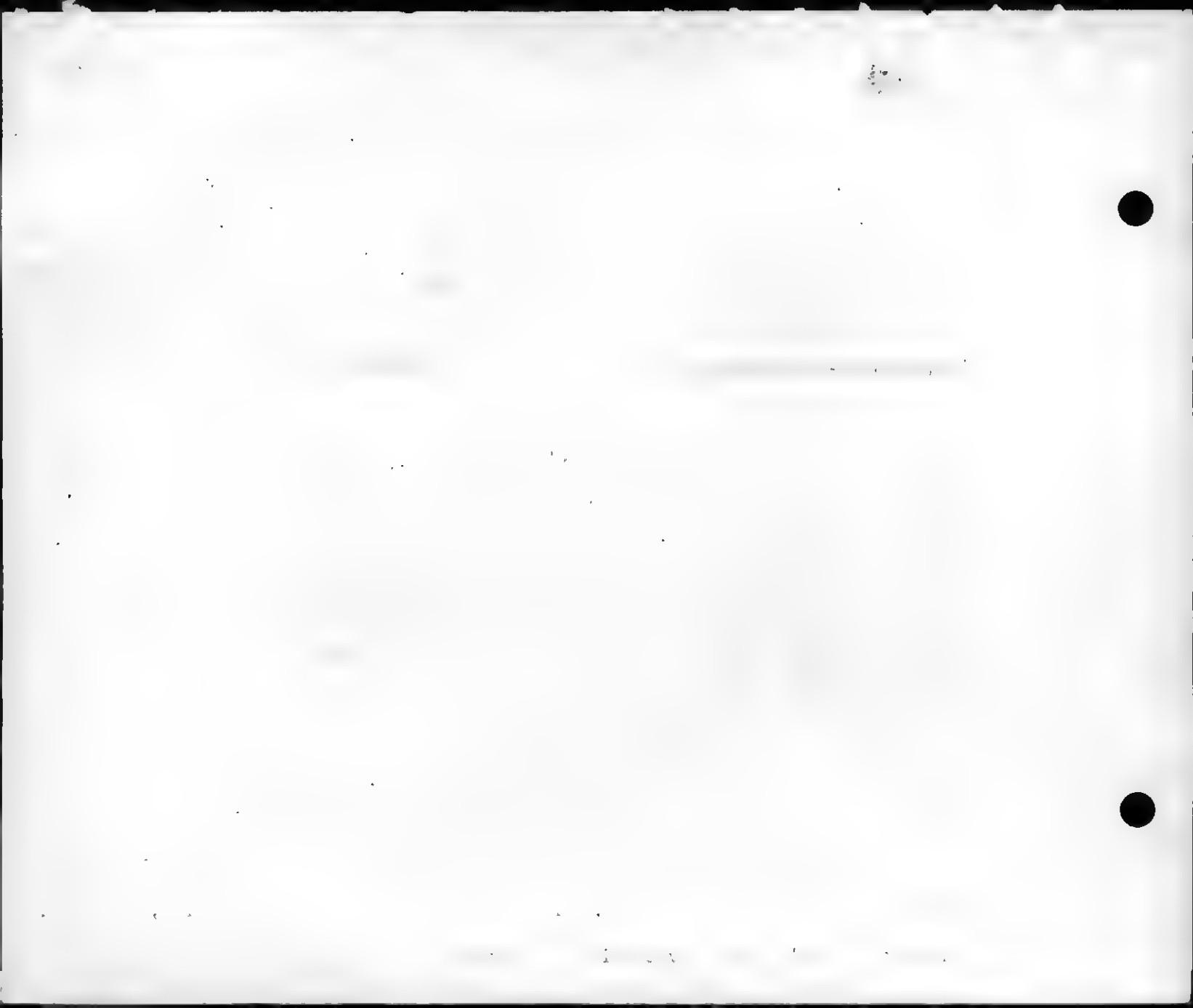
CERTIFICATE OF DEATH

04167		04158									
1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Week									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. STREET ADDRESS 7422 84 th. Ave.											
3. NAME OF DECEASED (Type or print) Milton		First	Middle	Last	4. DATE OF DEATH March 30, 1951	Month	Day	Year			
5. SEX male		6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH March 30, 1951	9. AGE (In years last birthday) 14 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School boy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Milton E. Dickey		14. MOTHER'S MAIDEN NAME Mary G. Goodwin									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Milton E. Dickey (same as no. 2)		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1441 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		Respiratory failure		INTERVAL BETWEEN ONSET AND DEATH minutes							
(b) DUE TO		Par lysis of respiratory muscles		days							
(c) DUE TO		Muscular dystrophy		9 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work p.m. 19 Not While at work					20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 3, 1966, to March 3, 1966, that (I) (we) last saw the deceased alive on March 3, 1966, and that death occurred at 3 AM M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John Kehoe</i>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.		22d. ADDRESS 6300 Riverdale Rd. Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 8, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City, town or county) Arlington Va.			(State)		
24. FUNERAL DIRECTOR W.W. Chambers Co.		ADDRESS Riverdale, Md.				25a. REC'D BY REGISTRAR MAR 8 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



17  
1 M  
10416R  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)															
a. COUNTY <i>Prince George</i> MARYLAND				a. STATE Maryland b. COUNTY Prince George															
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Riversdale</i>				c. LENGTH OF STAY IN lb <i>37 hrs</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Belair Memorial Hosp</i>				d. STREET ADDRESS <i>5704 36<sup>th</sup> Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Howard C. Cornwell</i>				First	Middle	Last	4. DATE OF DEATH <i>Dingee Jr.</i>	Month	Day	Year									
5. SEX <i>Male</i>				6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-26-05</i>	9. AGE (In years last birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor-Maintenance, City of Hyattsville</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Philadelphia Co., Pennsylvania U.S.A.</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Philadelphia Co., Pennsylvania U.S.A.</i>				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>Howard C. Dingee Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Gaynor Belle Counter</i>				Address <i>Hospital Records</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>177-01-5021</i>				17. INFORMANT <i>Howard C. Dingee Sr.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1/26/66</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i>																			
4201 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROTIC CORONARY HEART DISEASE</i>												2705.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 3-4, 1966, that (I) (we) last saw the deceased alive on 3-4 1966, and that death occurred at 7:00 PM, from the causes and on the date stated above.												22b. DATE SIGNED <i>3-4-66</i>							
22a. SIGNATURE <i>Ronald S. Fleischer</i>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <i>7411 Riggs Rd, Hyattsville 101</i>											
22c. PHYSICIAN'S NAME (Type) <i>Ronald S. Fleischer</i>				23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>3/7/66</i>				23c. NAME OF CEMETERY OR COLUMBIARIUM <i>Ft. Lincoln</i>				23d. LOCATION (City, town or county) (State) <i>Colmar Manor, Md.</i>			
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons</i>				25a. REC'D BY REGISTRAR <i>DATE 1966</i>				25b. REGISTRAR'S SIGNATURE <i>Francis Gasch's Sons</i>											
20M 1/65																			



**TO HOSPITAL**: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04169

04160

1. PLACE OF DEATH  
a. COUNTY

Prince Georges

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hyattsville

MARYLAND

c. LENGTH OF STAY IN lb

2 1/2 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

8910 Riggs Road

3. NAME OF  
DECEASED  
(Type or print)

First Middle  
Mother Melanie, R.J.M.  
Delia

5. SEX

F

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CATHOLIC NUN

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

Feb. 8, 1889

9. AGE (in years  
at birthday)

97 yrs.

IF UNDER 1 YEAR  
Months Dey

IF UNDER 24 HRS.  
Hours Min.

10b. KIND OF BUSINESS OR INDUSTRY

Religious Community

11. BIRTHPLACE (County & State, or foreign country)

Drumondville, P.Q. Canada

12. CITIZEN OF WHAT COUNTRY

Canada

13. FATHER'S NAME

Joseph Dionne

14. MOTHER'S MAIDEN NAME

Marie Jutras

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO

17. INFORMANT

Mother Mary Armand, R.J.M.

Address

8910 Riggs Road  
Hyattsville

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

4201 DUE TO

Conditions, I only, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Acute Pulmonary Edema

Myocardial Infarction

Arteriosclerotic Heart Disease

INTERVAL BETWEEN  
ONSET AND DEATH

3 hrs

3 hrs

10415

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20e. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (This Hospital) attended the deceased from... J.A.N. 1905 to 317.. 1966, that (I) (we) last

saw the deceased alive on 3/17 1966, and that death occurred at 6:00 AM, from the causes and on the date stated above.

22a. SIGNATURE

James L. Hauback

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED  
3/1/66

22c. PHYSICIAN'S  
NAME (Type)

James L. Hauback

22d. ADDRESS

1903 Wooded Way, Adelphi, Md

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

3-9-66

23c. NAME OF CEMETERY OR CREMATORIAL

REGINA CONVENT CEMETERY HYATTSVILLE, MARYLAND.

24. FUNERAL DIRECTOR'S SIGNATURE

X. Collins

ADDRESS

WASH. D.C.

25a. REC'D BY REGISTRAR

MAR 8 1966

25b. REGISTRAR'S SIGNATURE

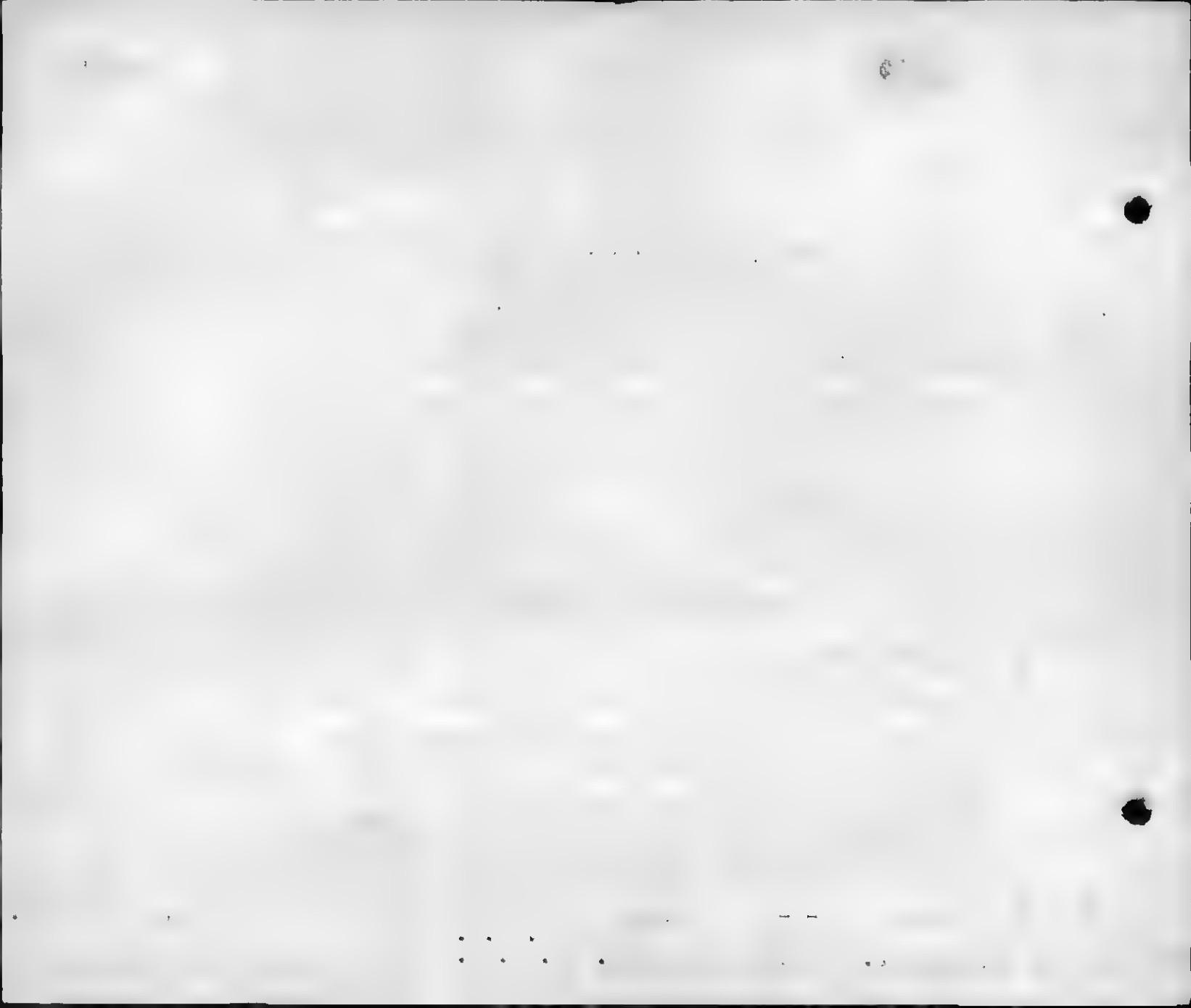
J. J. Judge

FRANCIS J. COLLINS 3821 14TH. ST. N. W.

D

14

1966



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

04170

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04163

1. PLACE OF DEATH  
a. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

15 days

c. LENGTH OF STAY IN 1D

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

d. STREET ADDRESS

5350 Quincy Pl.

e. IS RESIDENCE  
ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First Jessie

Middle

Last Dismuke

4. DATE  
OF  
DEATH

Month March

Day 5, Year 1966

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

12/4/95

9. AGE (in years  
last birthday)

70 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Prince George Co, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Mary Geiger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

579 26 1013

17. INFORMANT

Edward C. Dismuke Same as #2 (husband)

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1201

DUE TO

Conditions, if any, which  
gave rise to Immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
DNSET AND DEATH

2-18-66

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Acute ful Edema

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
While at work  Not White   
at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 18, 1966, to March 5, 1966, that (I) (we) last saw the deceased alive on March 5, 1966, and that death occurred at 1:15 PM, from the causes and on the date stated above.

22a. SIGNATURE

George J. Hageage

ATTENDING  
M.D. PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

3-5-66

22c. PHYSICIAN'S NAME (Type)

George J. Hageage, M.D.

22d. ADDRESS

3717 - 38th Ave., Cottage City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

2/8/66

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln

23d. LOCATION (City, town or county) (State)

Colmar Manor,

Md.

24. FUNERAL DIRECTOR

ADDRESS

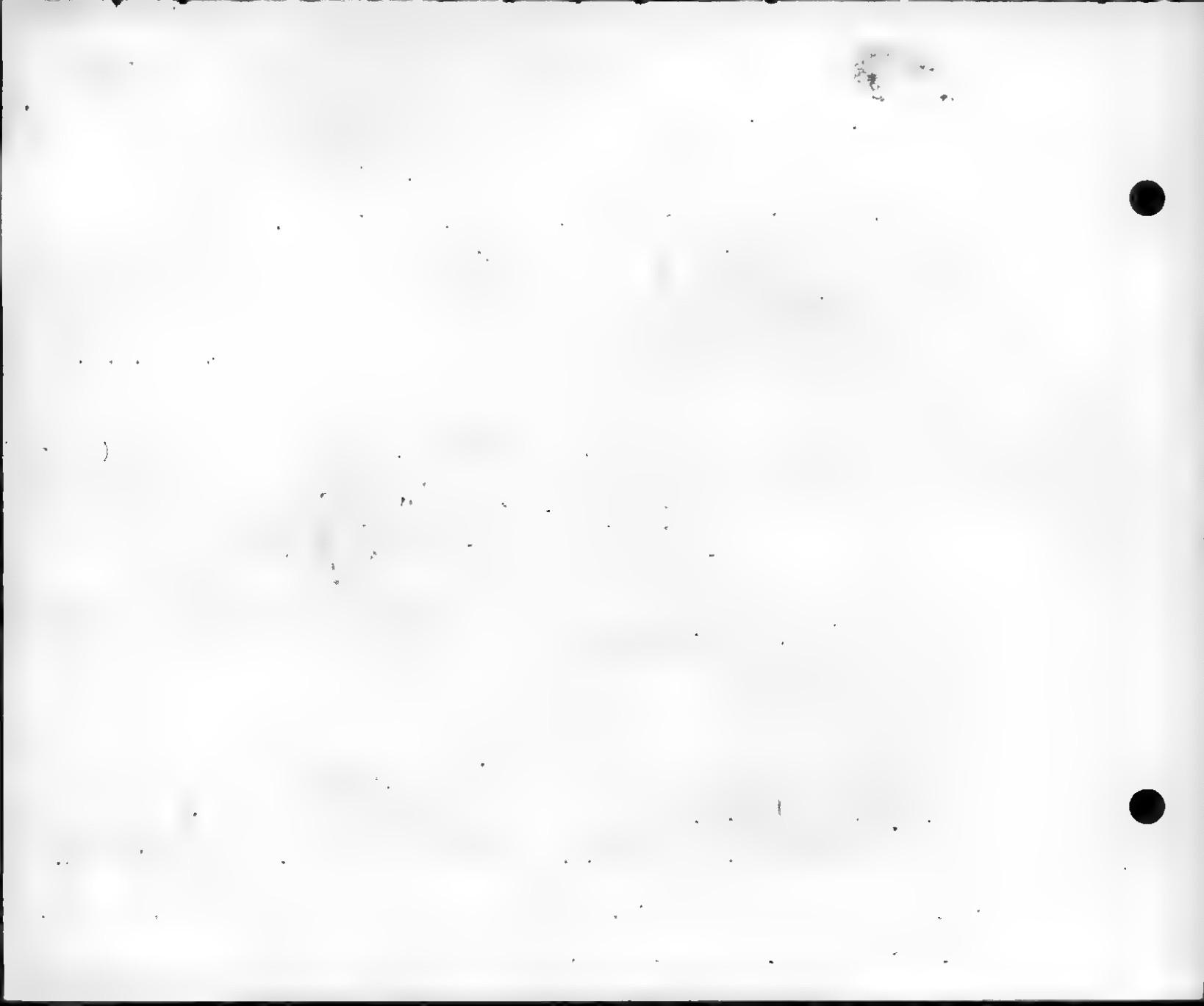
Francis Gasch's Sons Hyattsville, Maryland

25a. REC'D BY REGISTRAR

MAR 8 1966

25b. REGISTRAR'S SIGNATURE

Judge



FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

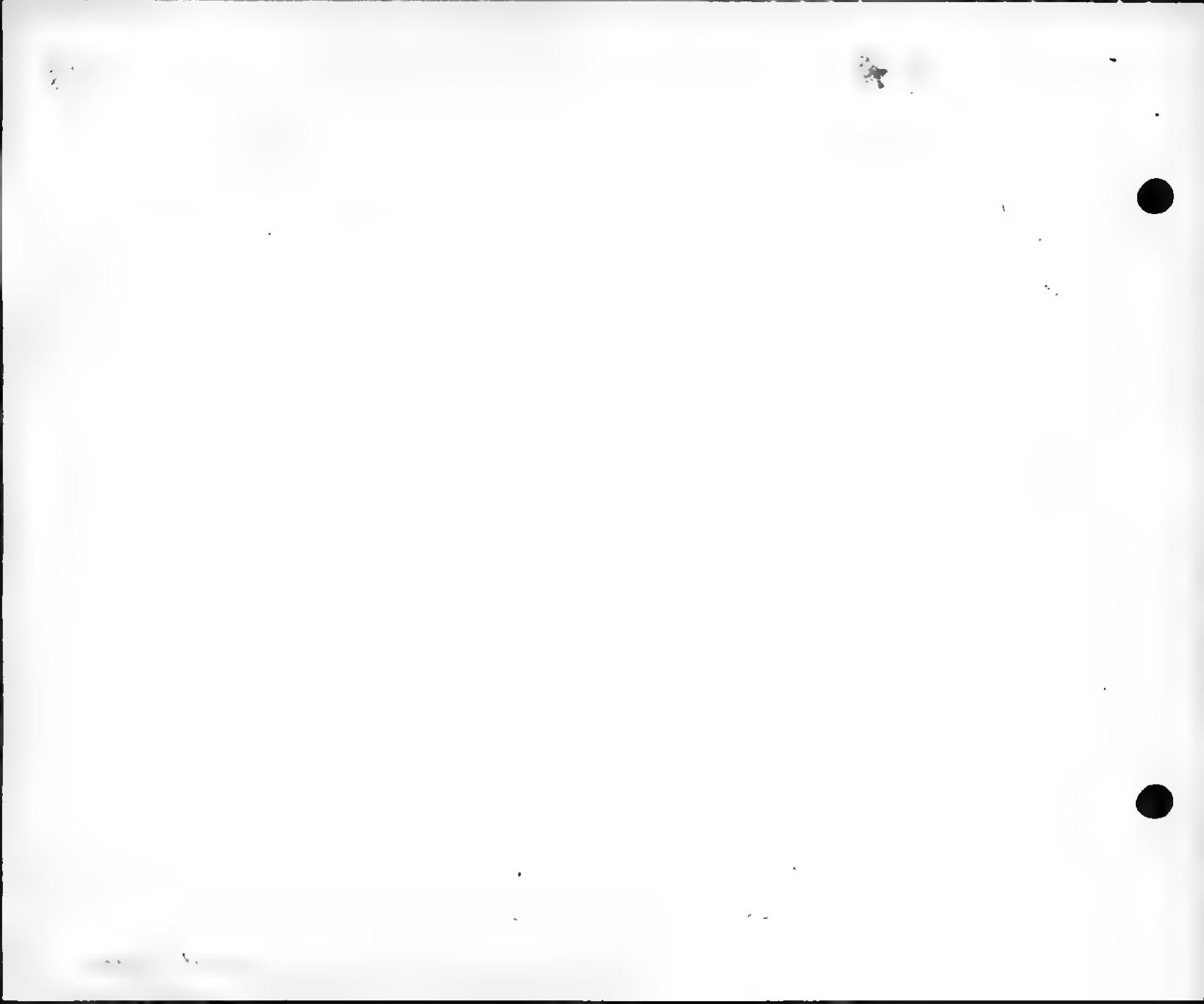
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 7 Film G-76 4/26/66 mb

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

105758

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>2 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>109 L Street, N.W.</b>			
3. NAME OF DECEASED (Type or print) <b>Willie</b>		First <b>Willie</b>	Middle <b>Dodson</b>		
4. SEX <b>Male</b>	5. COLOR OR RACE <b>Negro</b>	6. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	7. DATE OF BIRTH <b>unknown</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handy man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Junk yard</b>	9. AGE (In years lost birthday) <b>66(?) yrs</b>		
13. FATHER'S NAME <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT		
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). slating the underlying cause (b) DUE TO last. (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>3-22-66</b>
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-28-66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony Mem. Park</b>	23d. LOCATION (City or Town) <b>Pr.GEO. County Md</b>	
24. FUNERAL DIRECTOR <b>B.F.Taylor</b>		ADDRESS <b>909 6th St, N.W.</b>		25a. REC'D BY REGISTRAR <b>APR 20 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

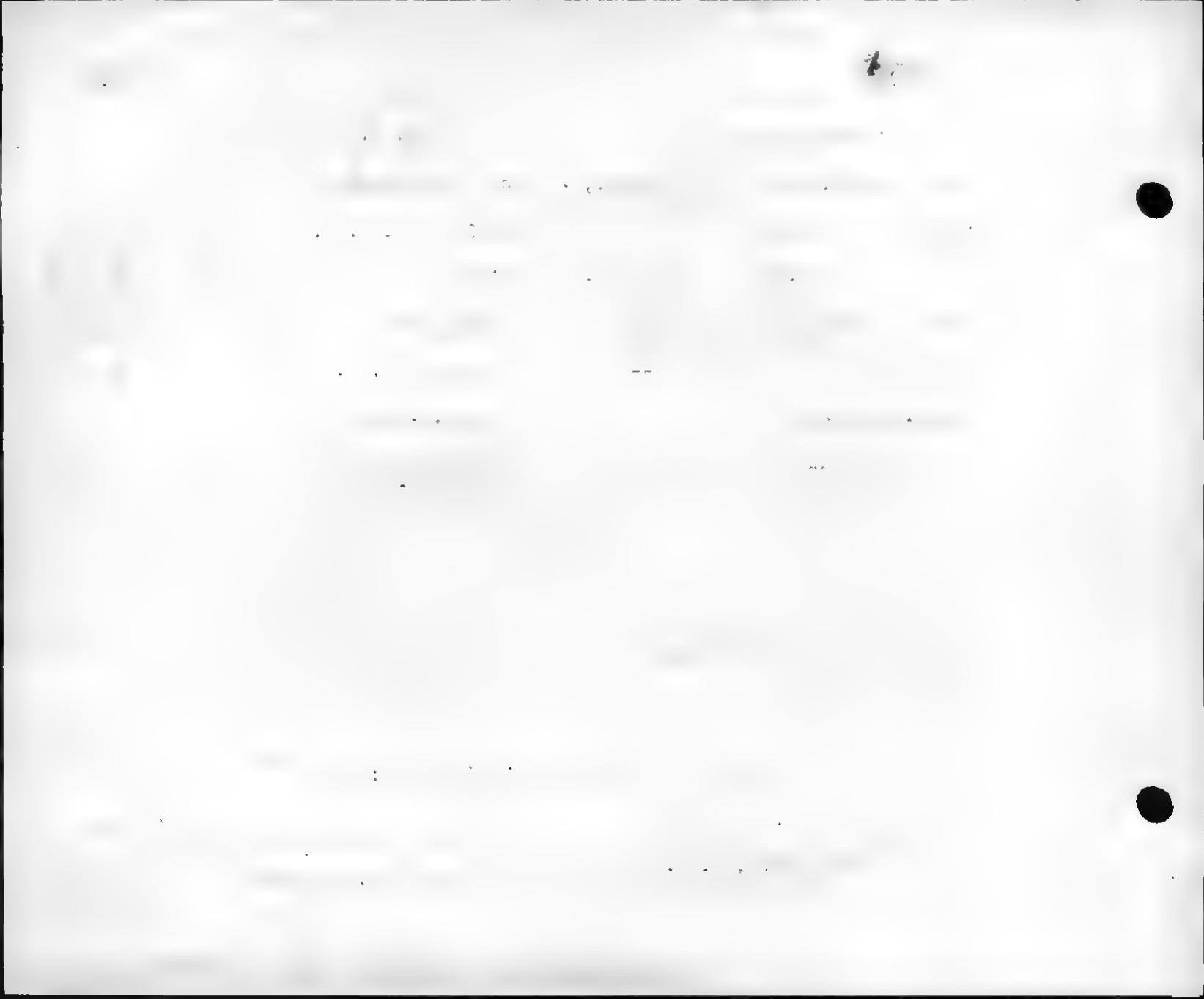
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and this event, within 72 hours after death.

04172

## CERTIFICATE OF DEATH

04162

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN lb <b>6 mos., 22 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
f. STREET ADDRESS <b>635 L St. N. W.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John B. Ellison</b>		First <b>John</b>	Middle <b>B.</b>
4. DATE OF DEATH <b>March 18 1966</b>	Month <b>March</b>	Day <b>18</b>	Year <b>1966</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12/4/1905</b>		9. AGE (In years old birthday) <b>60 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Dillon, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Ellison</b>		14. MOTHER'S MAIDEN NAME <b>Julia McCrae</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Decedent</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) with <b>gastrointestinal bleeding</b> DUE TO <b>acute diffuse peritonitis with pelvic and left</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>subphrenic abscesses</b> DUE TO <b>acute and chronic cystitis of the urinary bladder</b> (c) <b>with perforation of the urinary bladder (16 days)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. (City or town) <b>(County)</b> <b>(State)</b>
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>Aug. 24 1965</b> to <b>March 18 1966</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>March 18 1966</b> , and that death occurred at <b>12:05 A.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>3/18/66</b>	
22a. SIGNATURE <i>Moe Weiss</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Glen Dale Hospital</b>
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		23a. LOCATION (City or Town) <b>Glen Dale Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-25-66</b>		23b. DATE THEREOF <b>3-25-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Harmoney Mem. Park</b>
24. FUNERAL DIRECTOR <b>Johnson + Jenkins 4834 Ga. Avenue</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

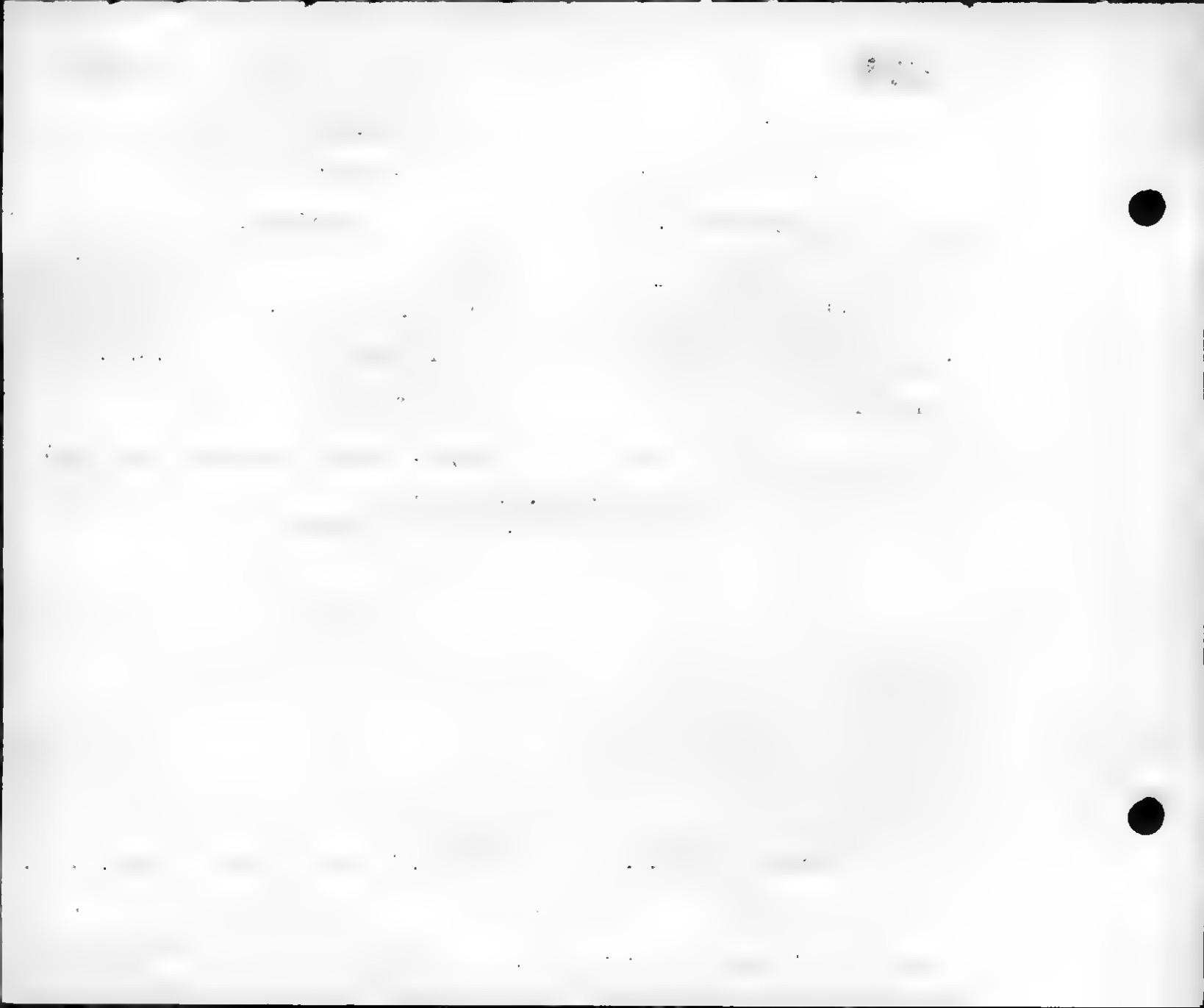
1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

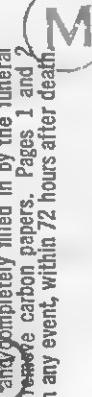
04173 04163

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>30 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>5229 42nd Place</b>	
3. NAME OF DECEASED (Type or print) <b>Helen Sara Eskite</b>	First <b>Helen</b>	Middle <b>Sara</b>	Last <b>Eskite</b>
4. DATE OF DEATH Month <b>March</b>	Day <b>22</b>	Year <b>1966</b>	5. SEX Female
6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>20 Dec., 1892</b>	9. AGE (In years last birthday) <b>73 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
13. FATHER'S NAME <b>Frank Fairfield</b>		14. MOTHER'S MAIDEN NAME <b>Jesse King</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Henry R. Eskite Same as #2 (husband)</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Emboli</b> DUE TO <b>Thrombophlebitis, left lower extremity</b> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <b>4-2, 1966</b>
20f. (City or town) <b>Suitland</b>		(County) (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4-2</b> , 1966, to <b>3-21</b> , 1966, that (I) (we) last saw the deceased alive on <b>3-21</b> , 1966, and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>C. Deitz</i>		22b. DATE SIGNED <b>3-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M.D.</b>		22d. ADDRESS <b>Prince George's Plaza, Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/25/66</b>	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City, town or county) (State) <b>Cedar Hill Suitland Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		ADDRESS	
		25a. REC'D. BY REGISTRAR <b>MAR 28 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health until to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <b>PRINCE GEORGES</b>			a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OXON HILL</b>			c. LENGTH OF STAY IN 1b <b>20 YRS</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5002 WHITE OAK DRIVE</b>			d. STREET ADDRESS <b>5002 WHITE OAK DRIVE</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
<b>MASSIMO</b>			<b>FERRARI</b>	<b>3 - 23</b>			<b>1966</b>					
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?					
<b>MALE</b>	<b>WHITE</b>	<b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>	<b>10-12-1891</b>	<b>74 yrs.</b>	<b>PRODUCE MERCHANT</b>	<b>SELF EMPLOYED</b>	<b>ITALY</b>	<b>U.S.A.</b>				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME											
<b>JOHN FERRARI</b>	<b>THERESA AMBROGI</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address									
<b>No</b>	<b>577-48-1629</b>	<b>CAROLINE C FERRARI</b>	<b>SAME AS 2D</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH											
<b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____</b>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of lung w/ metastases 6 weeks</b>												
MEDICAL CERTIFICATION			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
19			Feb			BALTIMORE MD			BALTIMORE MD			
21. I certify that (I) (this hospital) attended the deceased from Feb 1966 to Mar 22, 1966 that (I) (we) last saw the deceased alive on Mar 22, 1966, and that death occurred at M, from the causes and on the date stated above.												
22a. SIGNATURE <i>Massimo Ferrari</i>			22b. DATE SIGNED <b>3-24-66</b>									
22c. PHYSICIAN'S NAME (Type) <b>H.W. WISCONSIN MD</b>			M.D. ATTENDING <input checked="" type="checkbox"/> PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PNYS. PNYS. <b>3-24-66</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>3-26-1966</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>MT OLIVET CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>BLADENSBURG RD NE WASH, D.C.</b>			
24. FUNERAL DIRECTOR <b>W.W. Chambers Cbs 517-1128 STSE Wash, D.C.</b>			ADDRESS 25a. READ BY REGISTRAR <b>MAR 28 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

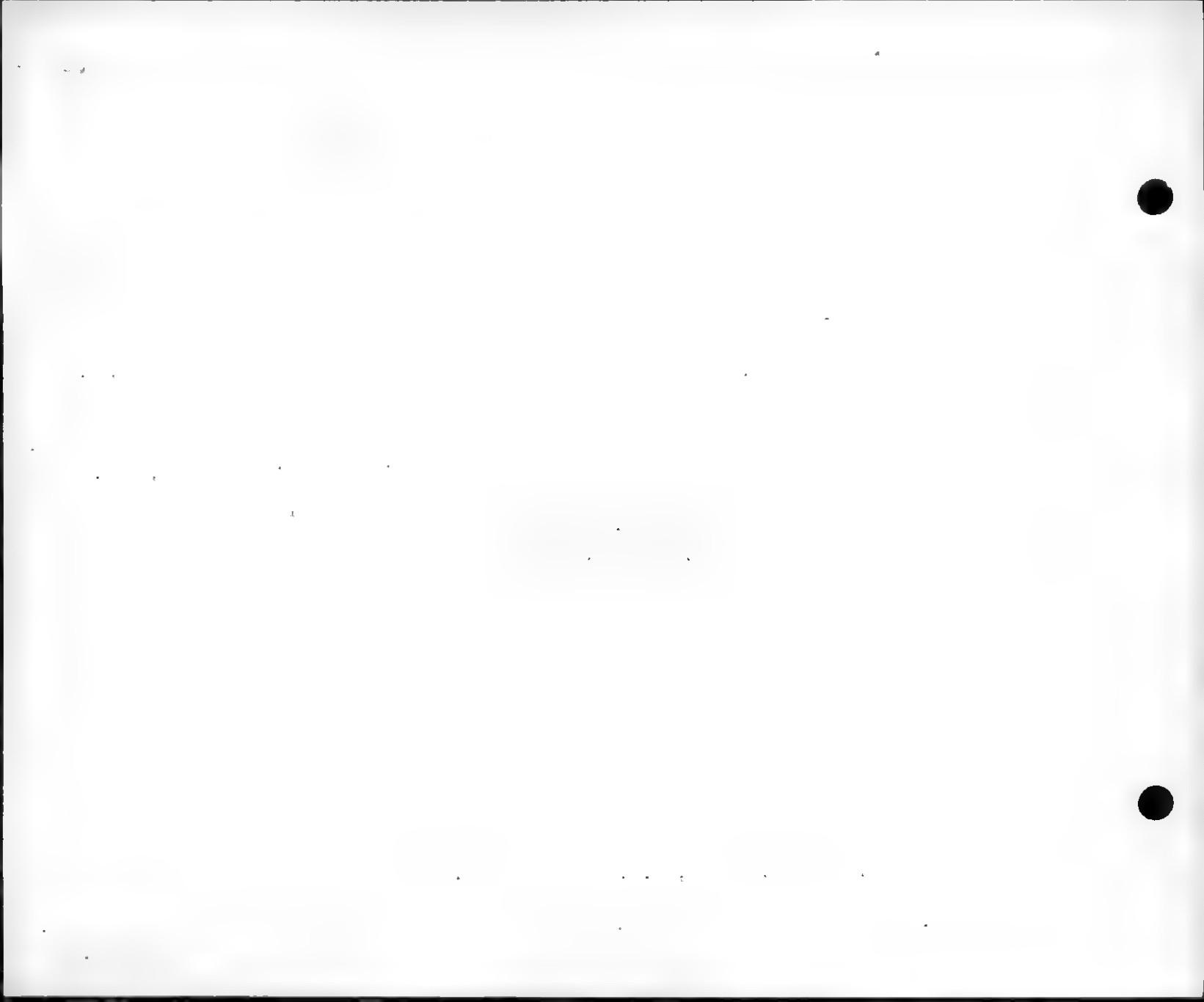
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04165

1 PLACE OF DEATH a COUNTY <b>Prince George</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c LENGTH OF STAY IN 1b <b>Hyattsville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>VIRGINIA GRAYSON FIELDS</b>		4 DATE OF DEATH Month Day Year <b>March 16, 1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>July 24, 1909</b>
9 DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mortgage Loan Dept.</b>		10 AGE (In years past birthday) <b>56 yrs</b>	
11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Grayson Carter</b>		14. MOTHER'S Maiden Name <b>Annie Marshall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Joannen Sullivan</b>		Address <b>306 Stemmers Run Rd. Baltimore 21, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Massive intracerebral hemorrhage, right internal capsule Cerebral arteriosclerosis</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20d. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20e. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>NONE</b>	
20f. TIME OF INJURY Month Day, Year Hour a.m. p.m. <b>19</b>		20g. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20h. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20i. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Cornelius J. Burns</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>Cornelius J. Burns, M.D. Cheverly, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>3/21/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04176

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04166

1. PLACE OF DEATH  
a. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly 2 days

c. LENGTH OF STAY IN 1D

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mitchellville

d. STREET ADDRESS

Box 1100

e. IS RESIDENCE ON A FARM?

YES  NO

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

Fletcher

March

26, 1966

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

3/1/1885

9. AGE (In years  
last birthday)

81 yrs.

IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Fletcher - Dennis Contee Ella Contee

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No None

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Rosie Brooks Mitchellville Md Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1x

Conditions, If any, which

gave rise to Immediate

cause (a), stating the

underlying cause last.

(b)

DUE TO

Arteriosclerosis

(c)

DUE TO

Arteriosclerosis

(d)

DUE TO

Arteriosclerosis

(e)

DUE TO

Arteriosclerosis

(f)

DUE TO

Arteriosclerosis

(g)

DUE TO

Arteriosclerosis

(h)

DUE TO

Arteriosclerosis

(i)

DUE TO

Arteriosclerosis

(j)

DUE TO

Arteriosclerosis

(k)

DUE TO

Arteriosclerosis

(l)

DUE TO

Arteriosclerosis

(m)

DUE TO

Arteriosclerosis

(n)

DUE TO

Arteriosclerosis

(o)

DUE TO

Arteriosclerosis

(p)

DUE TO

Arteriosclerosis

(q)

DUE TO

Arteriosclerosis

(r)

DUE TO

Arteriosclerosis

(s)

DUE TO

Arteriosclerosis

(t)

DUE TO

Arteriosclerosis

(u)

DUE TO

Arteriosclerosis

(v)

DUE TO

Arteriosclerosis

(w)

DUE TO

Arteriosclerosis

(x)

DUE TO

Arteriosclerosis

(y)

DUE TO

Arteriosclerosis

(z)

DUE TO

Arteriosclerosis

(aa)

DUE TO

Arteriosclerosis

(bb)

DUE TO

Arteriosclerosis

(cc)

DUE TO

Arteriosclerosis

(dd)

DUE TO

Arteriosclerosis

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Arteriosclerosis

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Arteriosclerosis

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DUE TO

Arteriosclerosis

(hh)

DUE TO

Arteriosclerosis

(ii)

DUE TO

Arteriosclerosis

(jj)

DUE TO

Arteriosclerosis

(kk)

DUE TO

Arteriosclerosis

(ll)

DUE TO

Arteriosclerosis

(mm)

DUE TO

Arteriosclerosis

(nn)

DUE TO

Arteriosclerosis

(oo)

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Arteriosclerosis

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Arteriosclerosis

(xx)

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Arteriosclerosis

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Arteriosclerosis

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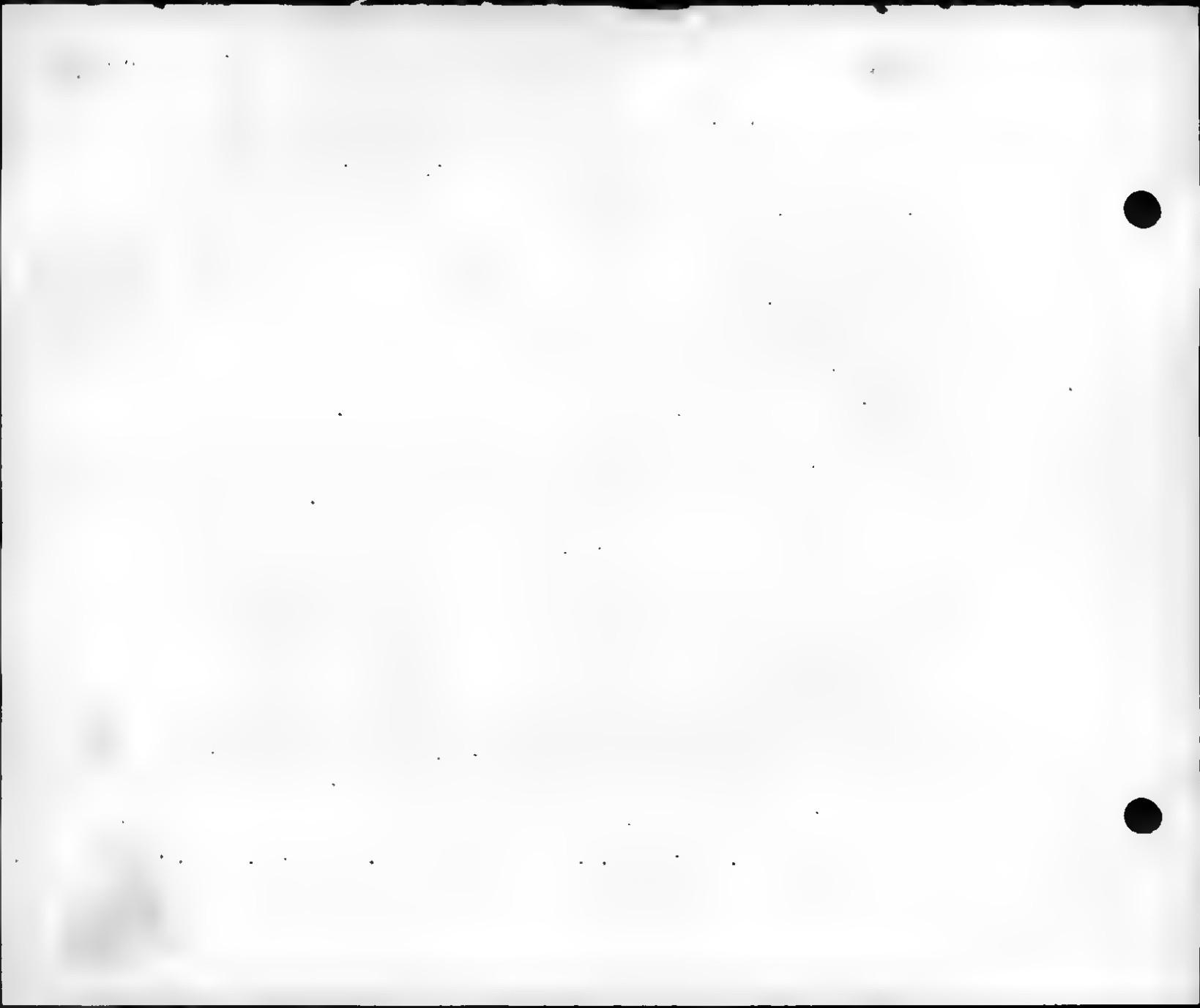
DUE TO

Arteriosclerosis

(gg)

DUE TO

Ar



**TO HOSPITAL**  **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04167

04177

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

W. Hyattsville

c. LENGTH OF STAY IN lb

3 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

— 6421 SARGENT RD

e. NAME OF  
DECEASED  
(Type or print)

f. SEX

Male

First Harvey Ellsworth

Middle

Last Fiory

4. DATE  
OF  
DEATH

Month March

Day 21

Year 1966

5. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

B. DATE OF BIRTH

Dec 23 1882

9. AGE (In years  
last birthday)

83 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work) 10b. KIND OF BUSINESS OR INDUSTRY

Farming & Mill Work

11. BIRTHPLACE (County & State or foreign country)

Roxbury Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Flory

14. MOTHER'S MAIDEN NAME

Rosie McConnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give year or date of service)

No None

16. SOCIAL SECURITY NO.

274-16-4192

17. INFORMANT

Mr. Ruth Flory

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate cause } (b)

(a), stating the underlying } DUE TO

cause last } (c)

Pneumonia, bronchial, acute

Cardiovascular Accident

Hypertension. Arteriosclerosis

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. While at work  Not While at work

p.m. 19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (the hospital) attended the deceased from March 20, 1966, to March 31, 1966, that (I) (we) last saw the deceased alive on March 20, 1966, and that death occurred at 3:30 AM, from the causes and on the date stated above.

22e. SIGNATURE

Philip E. Jones

22c. PHYSICIAN'S  
NAME (Type)

Philip E. Jones, M.D.

22d. ADDRESS

1600 Spring Hill Rd., Riverdale, Md.

M.D. ATTENDING PHYS  MED. DIRECTOR  STAFF PHYS.

22e. LOCATION (City, town or county)

Newton Falls, Ohio

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3-24-1966

23c. NAME OF CEMETERY OR CREMATORIAL

Newton Falls Cemetery

24. FUNERAL DIRECTOR'S SIGNATURE

W.W. Chambers Co.

ADDRESS

Riverdale, Md.

25. MORTALITY REGISTRATION DATE

MAR 24 1966

25b. MORTSTAR'S SIGNATURE

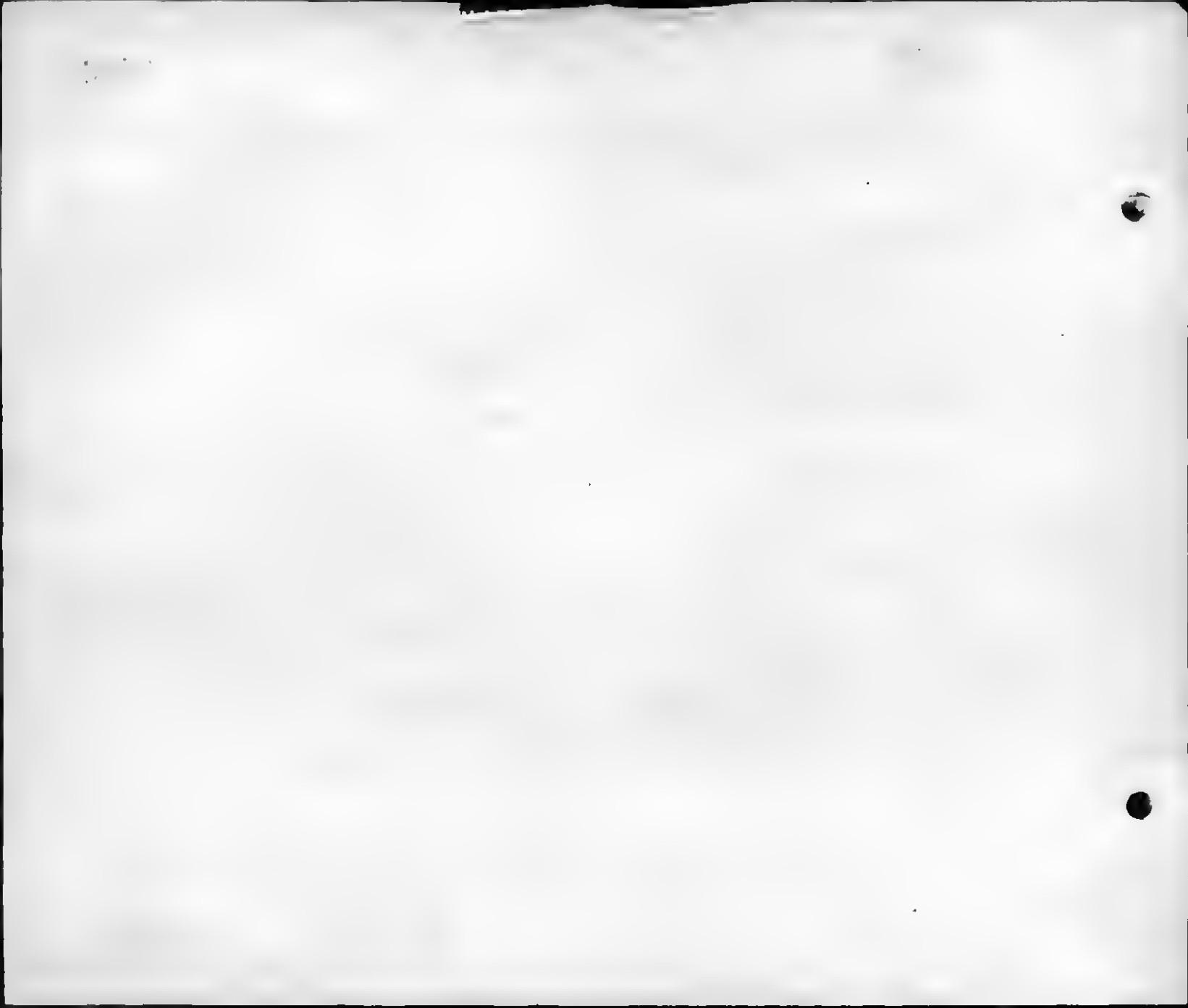
Charles Judge

e. IS RESIDENCE  
ON A FARM?  
YES  NO

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

2 yrs



1 M

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04178

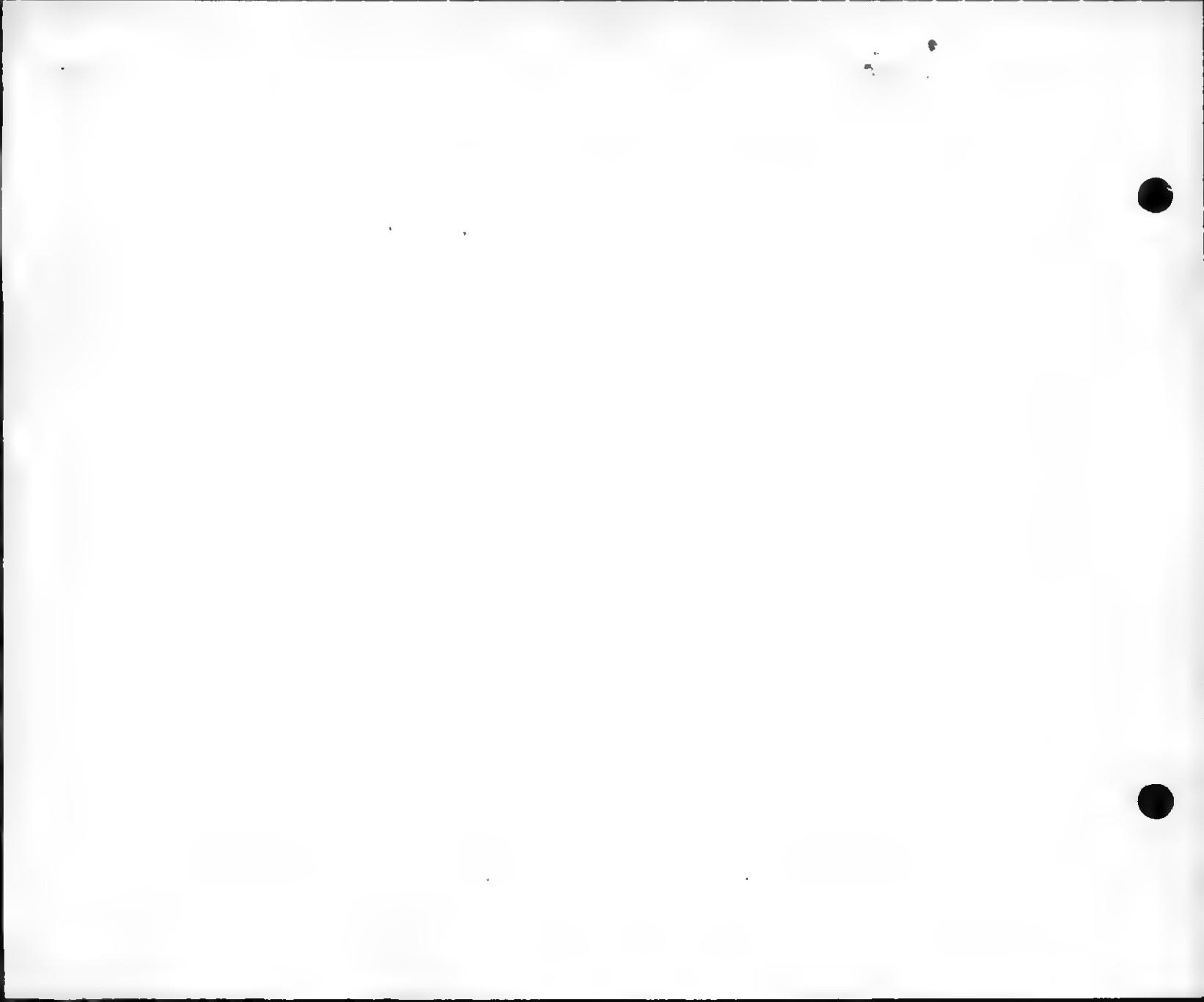
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04168

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		3. NAME OF DECEASED (Type or print)  Catherine									
				b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cheverly DCA		c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Rt. 1, Box 45		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. SEX Female		5. COLOR OR RACE Negro		6. MARRIED WIDOWED		7. NEVER MARRIED DIVORCED		8. DATE OF BIRTH 17 March 1908		9. AGE (In years lost birthday) 58 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.							
13. FATHER'S NAME John Weller		14. MOTHER'S MAIDEN NAME Linda June M.											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Henry Ford		18. ADDRESS Hyattsville, Md.							
19. INTERVAL BETWEEN ONSET AND DEATH minutes													
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Arteriosclerotic heart disease DUE TO (c)											
unknown													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Diabetes - over 10 years													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 3-23-66					
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.													
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF 1966		23c. NAME OF CEMETERY OR CREMATORIAL FACILITY Riverdale Cemetery		23d. LOCATION (City or Town) Riverdale, Md.		(County) (State)					
24. FUNERAL DIRECTOR Charles Judd		ADDRESS Delson Law Stone		25a. REG'D BY REGISTRAR MAR 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judd							



1 M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

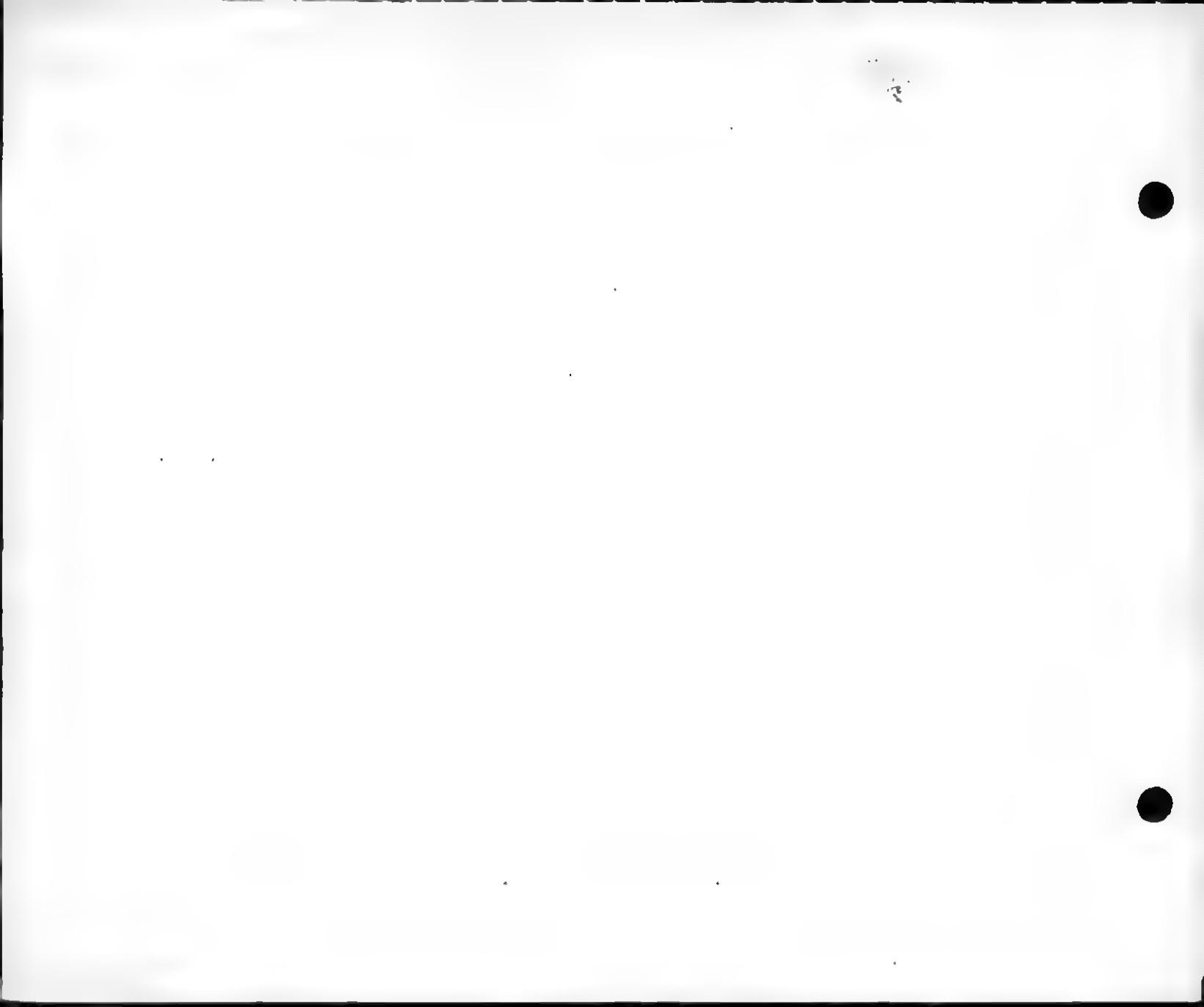
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04169

04169

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) Lershing Drive		e. STREET ADDRESS Lershing Drive	
3. NAME OF DECEASED (Type or print) Lewis		First	Middle
4. SEX Male		5. COLOR OR RACE White	6. MARRIED W DIVORCED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
7. MARRIED <input checked="" type="checkbox"/> W DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 June 1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		9. AGE (In years lost birthday) 76 yrs	
10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John B Ford		12. CITIZEN OF WHAT COUNTRY? S A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service --		16. SOCIAL SECURITY NO 379 01 8424	
17. INFORMANT John Ford		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure + 200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, town, or county) 3-16-66	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 19, 1966	23c. NAME OF CEMETERY OR Crematory Mt Olivet Cemetery
23d. LOCATION (City or Town) (County) (State)		Washington D.C.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. ADDRESS Hyattsville, Md.	25b. REC'D BY REGISTRAR MAR 21 1966
25b. REC'D STAR'S SIGNATURE Charles Judge			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

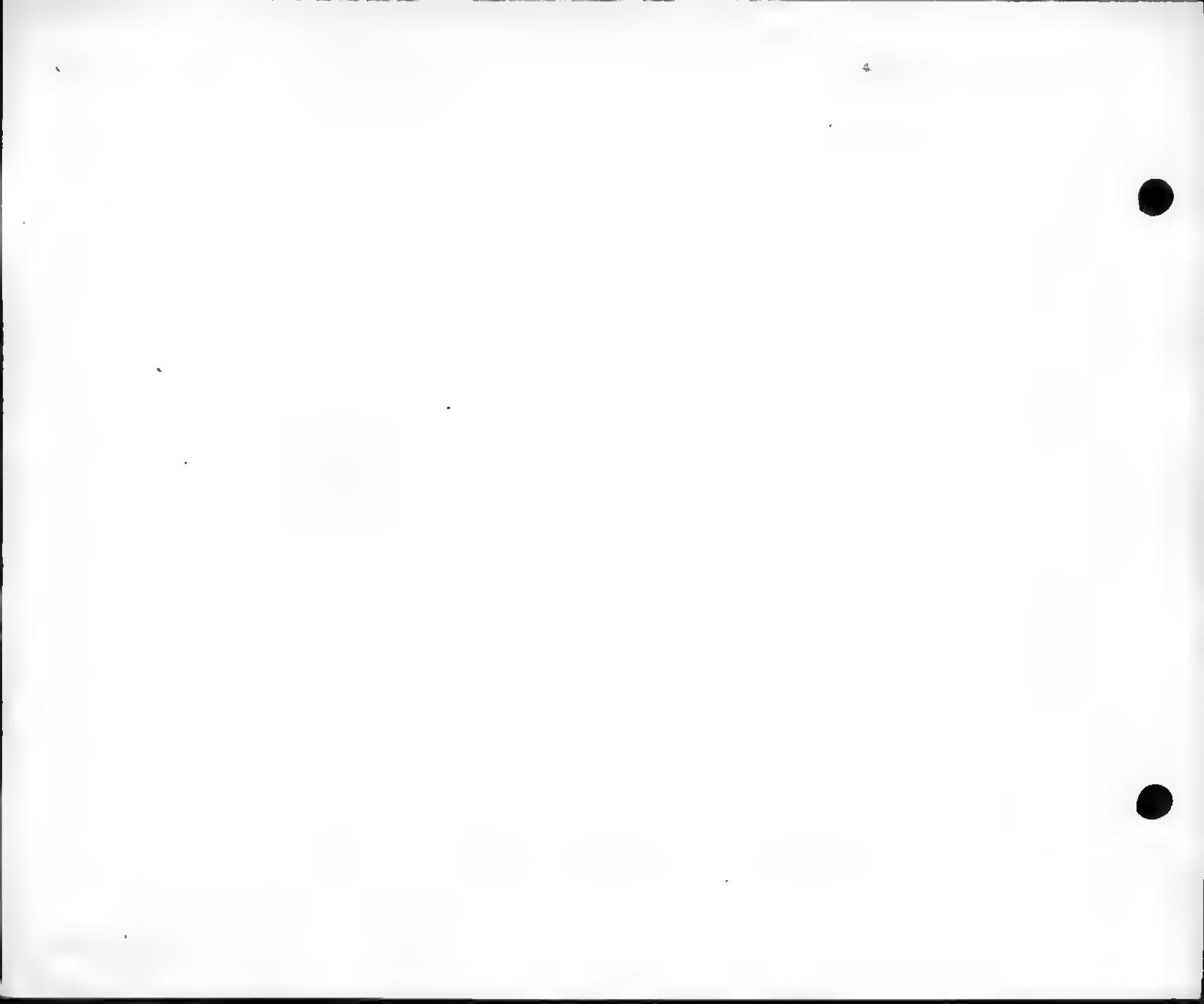
04170

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil after Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

1 PLACE OF DEATH a COUNTY Prince George's Maryland		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Helena		First Middle Katherine	Last Fraber
4 DATE OF DEATH 3 19 1966	Month Month Year Year		
5 SEX female	6 COLOR OR RACE white	7 MARRIED WIDOWED	8 NEVER MARRIED DIVORCED
9 AGE (In years last birthday) 78 yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NOT SEWING</i>	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) WASHINGTON D.C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.	13 FATHER'S NAME John SULLIVAN		
14 MOTHER'S Maiden Name BRIDGET		Address WILLIAM J. FRABER - MT. RAINIER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO.			
17 INFORMANT (Husband)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH minutes over 1 week			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John N. Kehl</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John N. Kehl, M.D., Riverdale, Maryland	
22. DATE SIGNED 3-19-66			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3/22/66	23c NAME OF CEMETERY OR CREMATORIUM MT. CHIVET CEMETERY
24. FUNERAL DIRECTOR NOLLEY FUNERAL HOME		ADDRESS MT. RAINIER, MD	25a RECEIVED BY REGISTRAR MAR 24 1966
			25b REGISTRAR'S SIGNATURE Charles Judge



FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

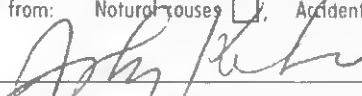
04181

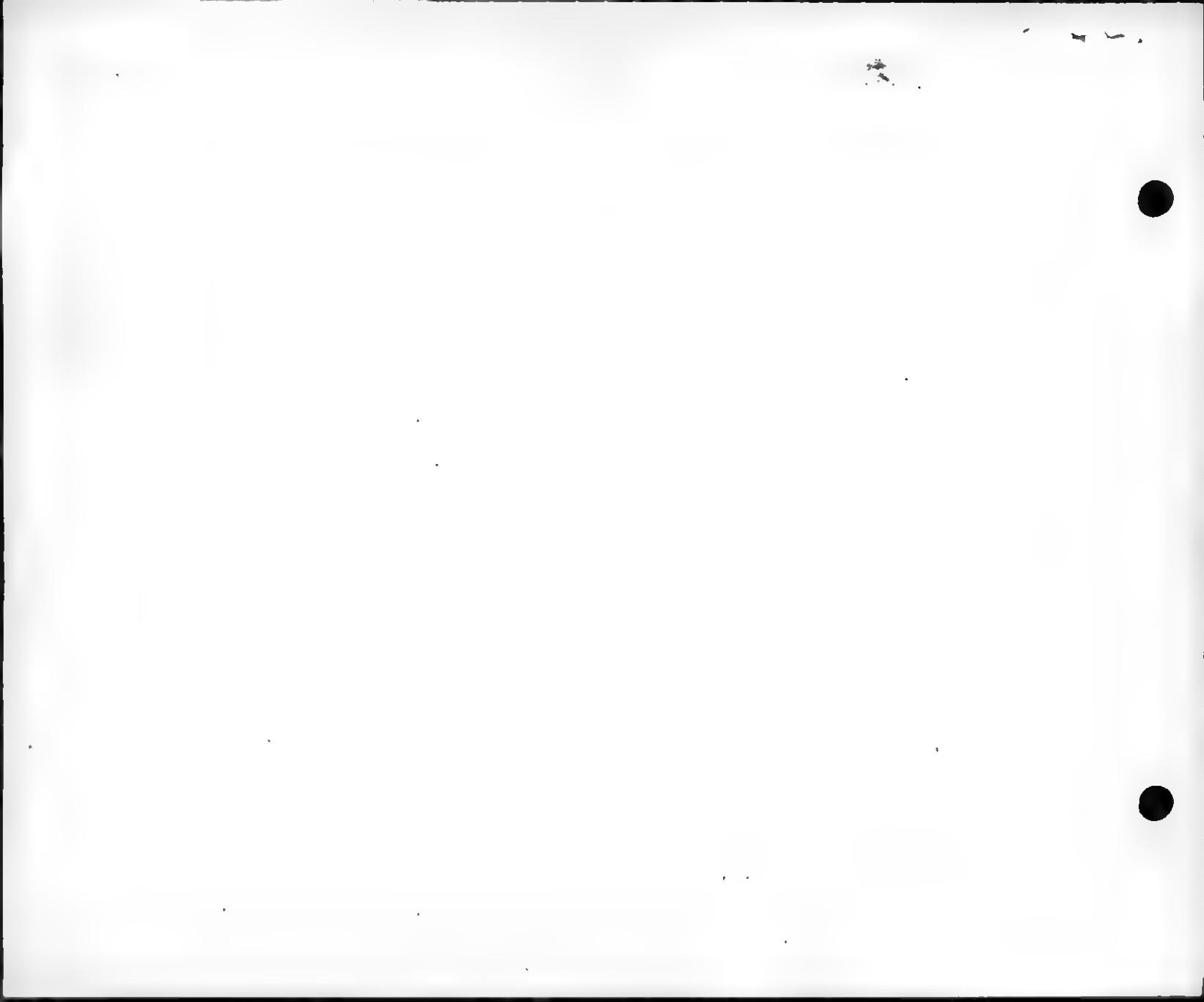
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04171

To DENTAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in Part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transfer permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

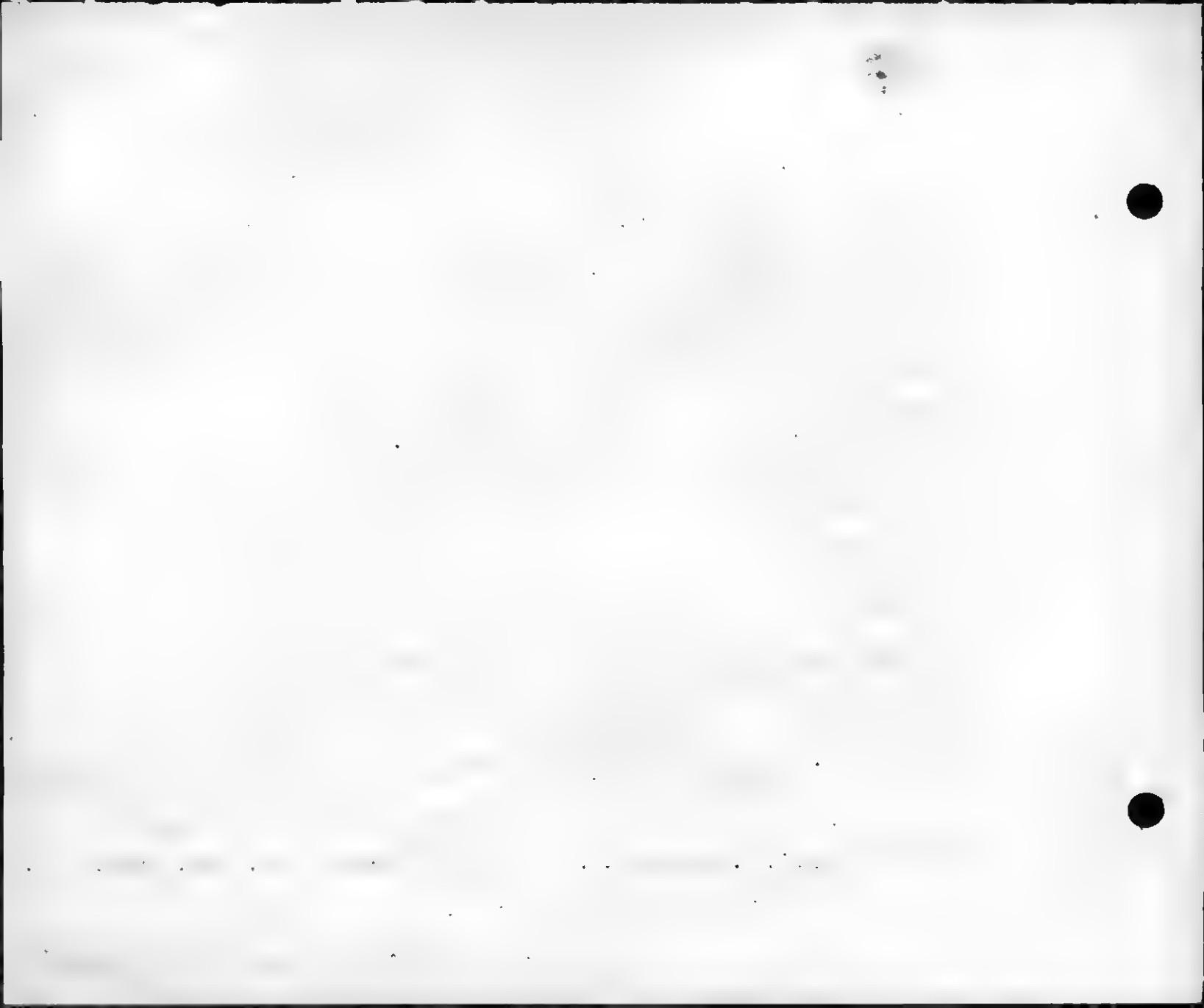
1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		d. STREET ADDRESS 8602 Rochier Street				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8602 Rochier Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Georgia		First Gordon	Middle Franklin	4. DATE OF DEATH 3	Month 6	Day 1966	Year			
S. SEX female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 7-11-19	9. AGE (In years 46 last birthday) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Rockingham, N. C.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Rath Franklin				14. MOTHER'S MAIDEN NAME Henrietta Franklin		Address Edward L. Franklin-8602 Rochier Street				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOC. SEC. SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Asphyxiation</u>  74X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>hanging</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 20 or Part 1 of item 18) hung self in basement of home		20c. TIME OF INJURY Month, Day, Year Hour a.m. ab. 3PM p.m. 3-6 1966		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> home		20e. (City or town) Landover	(County) D.G.	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect.on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 3-7-66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-66		23c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		23d. LOCATION (City or Town) Arlington, Virginia		(County) (State)		
24. FUNERAL DIRECTOR John T. Rhines Co.		ADDRESS 3015 12th Street N. E. D. C.		25a. REC'D BY REGISTRAR MAR 11 1966		25b. REGISTRAR'S SIGNATURE 				



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item # 04182 Date 04/17/66											
1. PLACE OF DEATH a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
Maryland			1100 Prince George's General Hospital			2 days			a. STATE	b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)									c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		
Prince George's General Hospital									Fairmount Union		
e. STREET ADDRESS									f. IS RESIDENCE ON A FARM?		
									YES <input type="checkbox"/>	NO <input type="checkbox"/>	
g. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
						Dec. 25, 1985	1885	25	1985	19	
5. SEX			6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 YEAR Months	11. UNDER 24 HRS Days	12. HOURS Hours	13. MINUTES Min.	
					Dec. 25, 1983	yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY? USA		
None						Maryland					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Jack Watkins			Mary (unknown)								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
						Mrs. Julia C. Chapman 1715 Franklin St. N.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebrovascular Accident								
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the			(b) Vascular Hypertension + Sclerosis								
DUE TO underlying cause last.			(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from March 19, 1966, to March 21, 1966, that (we) last saw the deceased alive on March 21, 1966, and that death occurred at . . . M, from the causes and on the date stated above.											
22a. SIGNATURE									22b. DATE SIGNED		
Edwin J. Jensen									3/22/66		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			Prince George's Genl. Hosp. Cheverly Md.					
Edwin J. Jensen, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town or county) (State)		
Burial			3/26/66			Harmony Memorial Park			Maryland		
24. FUNERAL DIRECTOR			John J. Stewart			ADDRESS			25a. REC'D BY REGISTRAR		
									25b. REGISTRAR'S SIGNATURE		
									MAR 28 1966 J Charles Judge		
Stewart Funeral Home 4001 Benning Road											
VR A15 (4) 2DM 1/65											



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

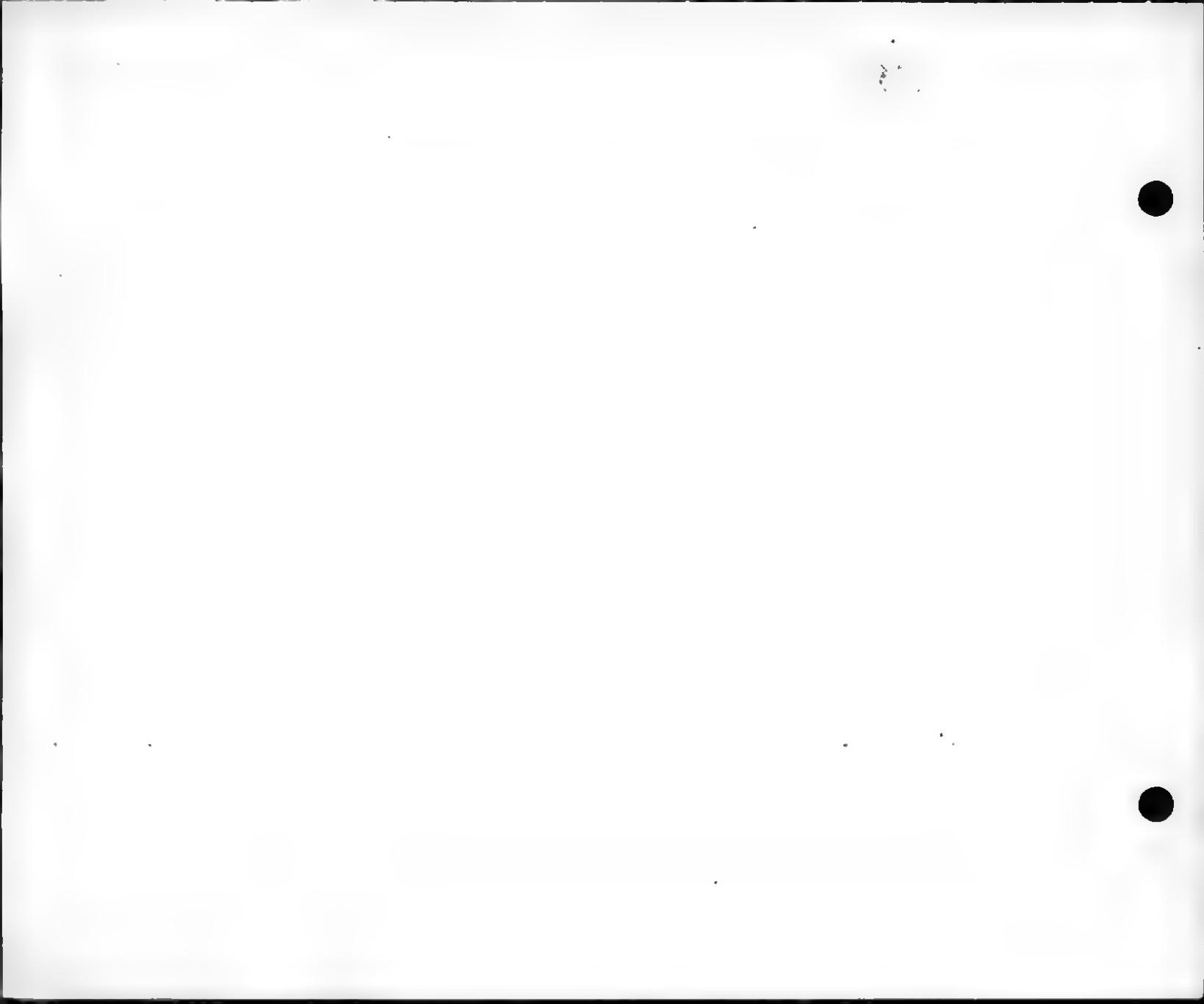
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City delay is necessary please execute the certificate, writing the word "pending" in part I item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04188

04173

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		c. LENGTH OF STAY IN 1b N/A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		d. STREET ADDRESS <b>4919 Naples Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4919 Naples Avenue</b>				e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Delbert</b>	Middle <b>Alvin</b>	Surname <b>Friend</b>	4. DATE OF DEATH Month <b>3</b>	Month <b>26</b>	Day <b>19</b>	Year <b>66</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-16</b>	9. AGE (In years last birthday) <b>49 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WAREHOUSE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN H. FRIEND</b>		14. MOTHER'S MAIDEN NAME <b>LAURA V. UPHOLD</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b> <b>W.W. II</b>		16. SOCIAL SECURITY NO. <b>213 129 268</b>		17. INFORMANT <b>EVELYN B FRIEND</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		shotgun wound of chest					
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
(b)							
DUE TO  (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>shot self with 12 gauge shotgun</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2:00pm p.m. 3-26 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Beltsville I.G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>John Kenoc H.D., Riverdale, Maryland</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-30-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>		ADDRESS <b>Riverdale, Md.</b>		25a. REC'D BY REGISTRAR D <b>MAR 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**M FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Page 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

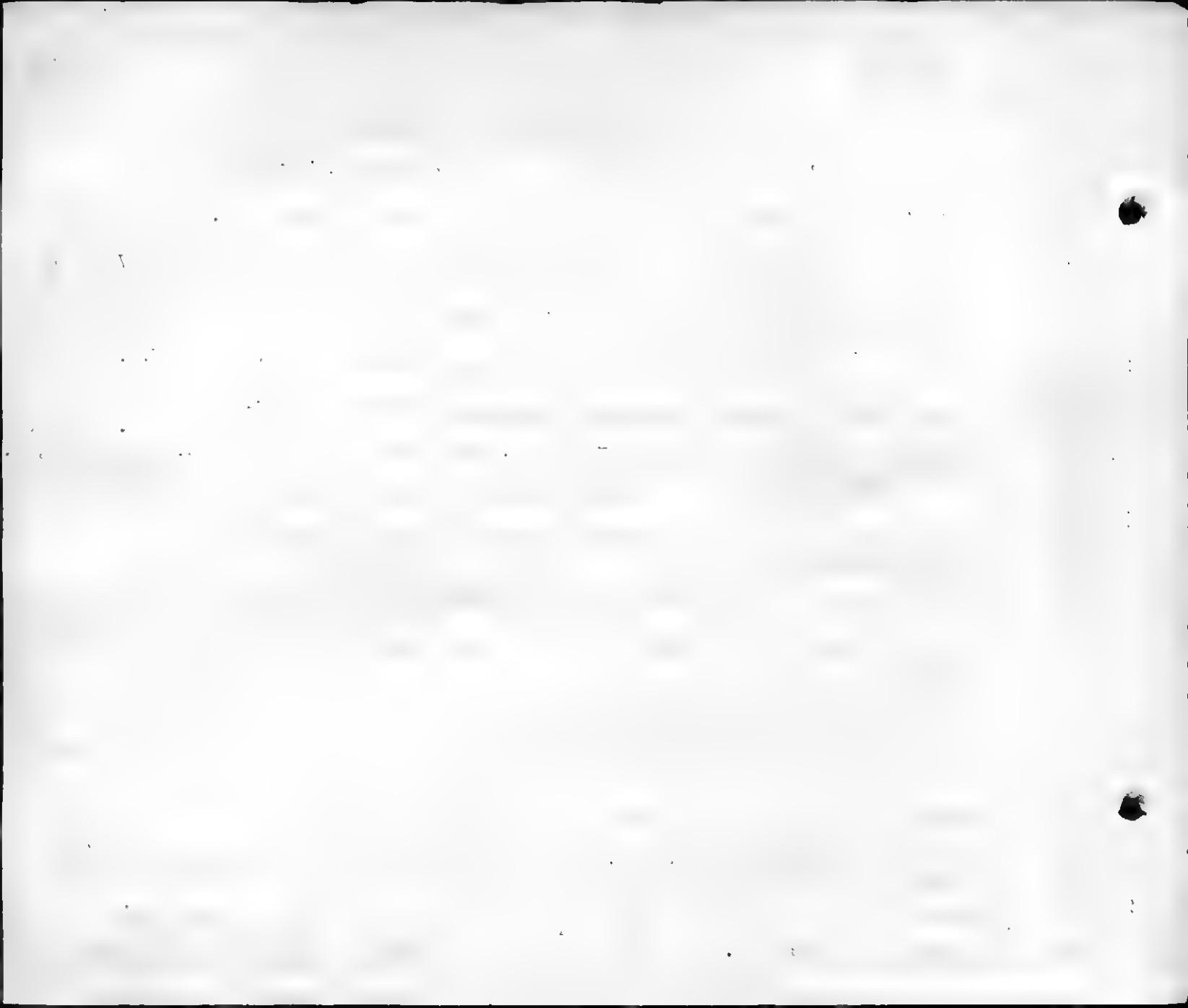
**MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**04184**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**04174**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Prince George's Maryland		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland		b. COUNTY Prince George's	
c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 3405 Toledo Terrace, Apt. K	
3. NAME OF (Type or print)		Last 4. DATE OF DEATH Month Day Year	
Edward Dean Fugitt		March 17 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1895	
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. AGE (in years, last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Congressional Secretary (Retired)		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME Eugene Fugitt	
14. MOTHER'S MAIDEN NAME Meriam Skinner		Address 4006 Crittenden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-60-0126	
17. INFORMANT Mrs. Elsie Smallwood -Sister St. Hyattsville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		Thrombosis, anterior coronary artery	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b) Arteriocardiovascular disease, severe			
} DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Cornelius J. Burns, M.D.			
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 3/17/66			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial 3/21/66		Address (Street, city, town, or county) Cheverly, Maryland	
22f. DATE THEREOF		(State)	
22g. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.	
24e. REC'D BY REGISTRAR MAR 23 1966 24b. REGISTRAR'S SIGNATURE Charles Judge			
23. FUNERAL DIRECTOR Nalley's Funeral Home Inc. ADDRESS Mt. Rainier, Maryland			
VR AISM 5M 1/63			



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

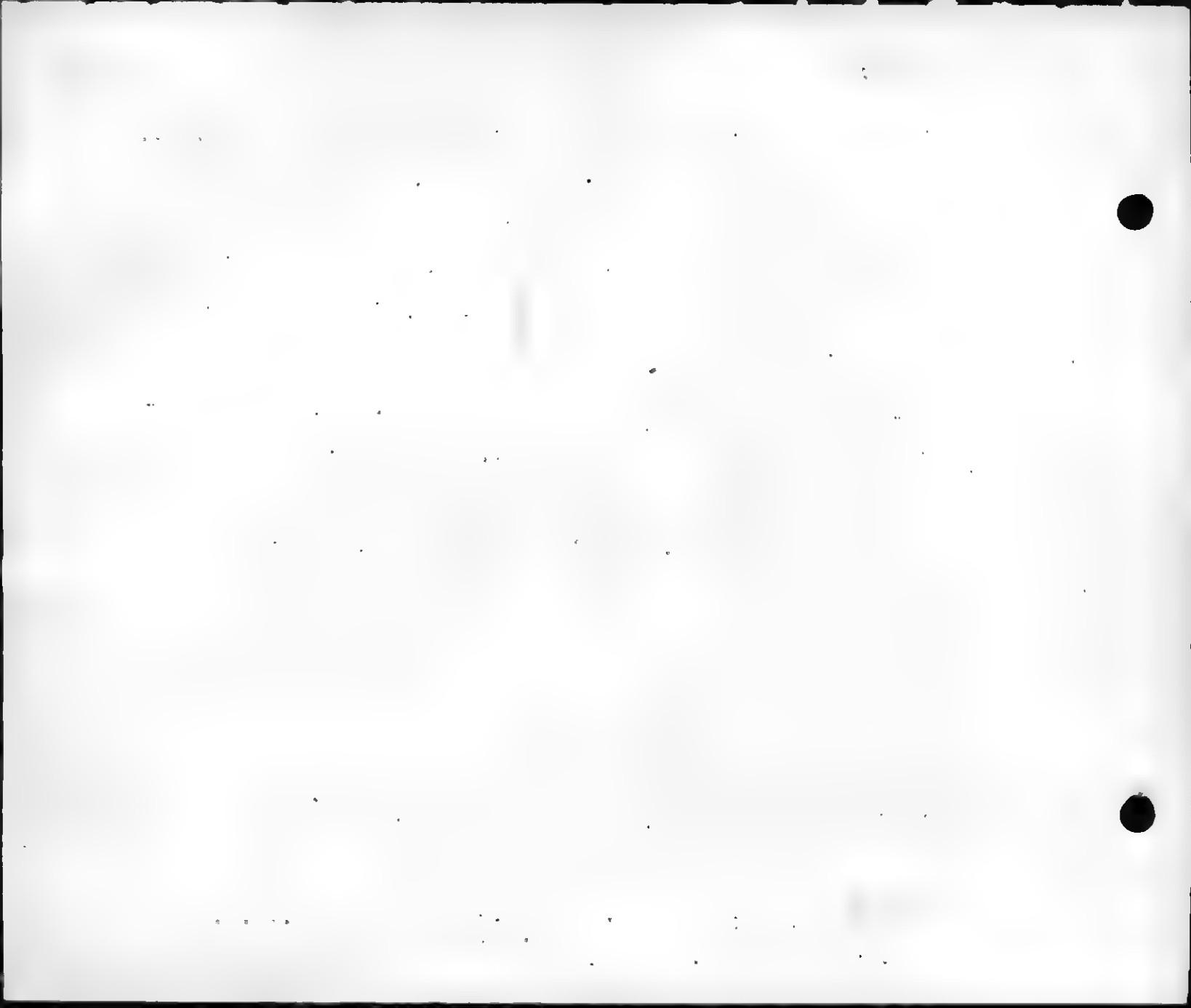
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b 2 mo. 18 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hyattsville Nursing Home 6500 Riggs Rd.</i>		e. STREET ADDRESS <i>3600 Varnum</i>			
3. NAME OF DECEASED (Type or print) <i>JOSEPH</i>		First <i>W</i>	Middle <i>G</i>		
Last <i>GERHARDT</i>		4. DATE OF DEATH Month <i>3</i>	Day <i>21</i>		
5. SEX <i>m</i>		6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mail carrier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>			
13. FATHER'S NAME <i>JULIUS I GERHARDT</i>		8. DATE OF BIRTH Year <i>6/4/1882</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		9. AGE (in years last birthday) 83 yrs.			
16. SOCIAL SECURITY NO. <i>None</i>		10. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Md.</i>			
17. INFORMANT <i>Mr. Karl Gerhardt (above address)</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>Advanced arterio sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	
				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/25, 1966</i> , to <i>3/21, 1966</i> , that (I) (we) last saw the deceased alive on <i>3/20, 1966</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Louis Mendel</i>					
22b. DATE SIGNED <i>3/22/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>C. LOUIS MENDEL</i>		ATTENDING M.D. PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>4410-74 ave Hyattsville Rd</i>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <i>Burial 3/24/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>St. Mary's Cemetery Mt. Rainier, Maryland</i>		23d. LOCATION (City, town or county) (State) <i>Wash. D.C.</i>	
24. FUNERAL DIRECTOR <i>Nallely's Funeral Home Inc.</i>		25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
		DATE <i>MAR 28 1966</i>			



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

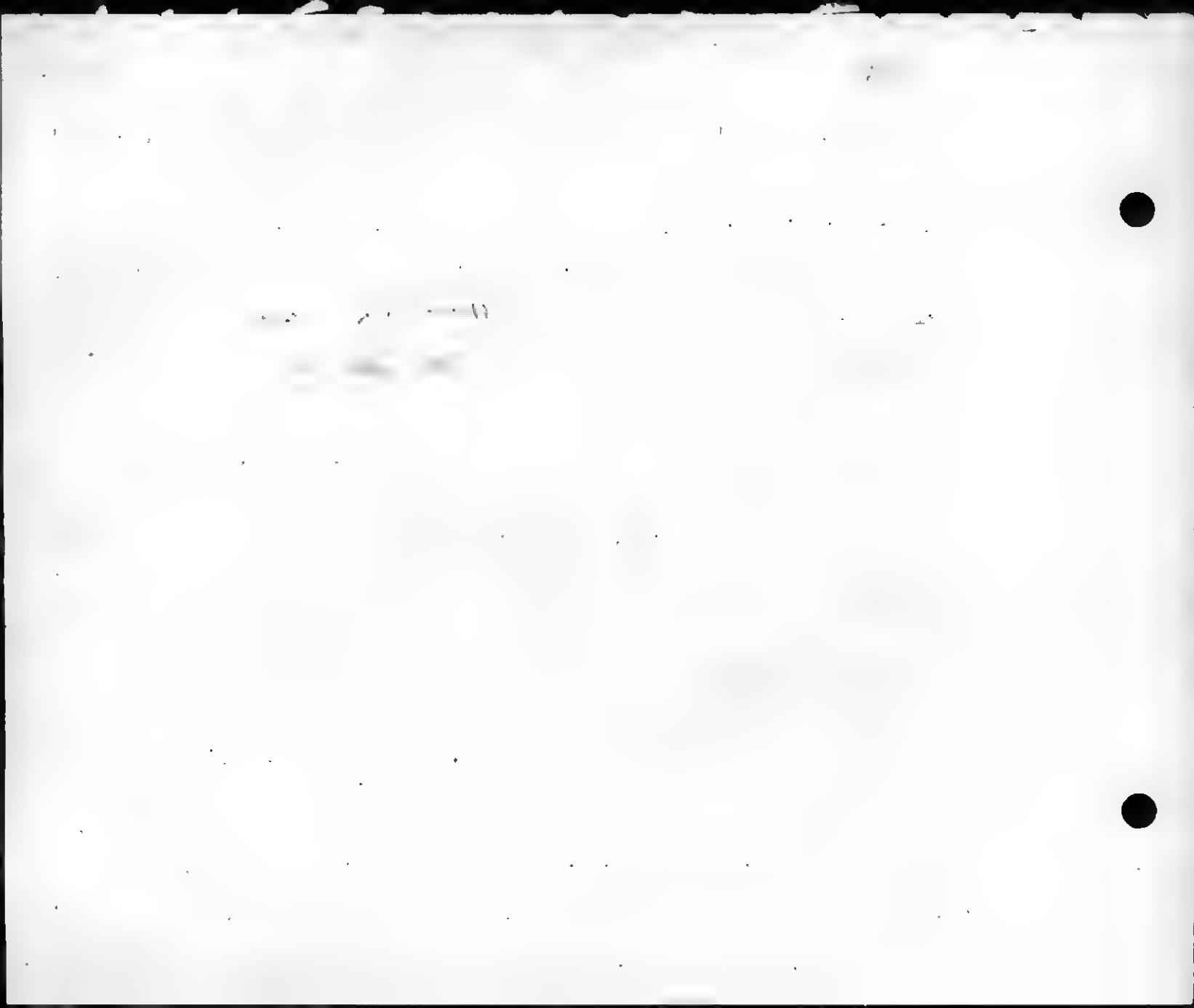
04186

CERTIFICATE OF DEATH

04176

Item 9 Film 3375  
1/20/66 mb

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY Maryland Pr. George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b Two weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
3. NAME OF DECEASED (Type or print) First Eva Middle Lena Last Giles		4. DATE OF DEATH Month March Day 18 Year 1966	
5. SEX Female Cauc.		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-4-82		9. AGE (In years) 83 last birthday 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PR. Geo. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William O'Gray		14. MOTHER'S MAIDEN NAME Mary Bowler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Jane Printz, Lanham, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
Cerebro-vascular Accident Gen. Arteriosclerosis		Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1962, to March 18, 1966, that (I) (we) last saw the deceased alive on March 17, 1966, and that death occurred at 3:20 P.M., from the causes and on the date stated above.		22b. DATE SIGNED March 18, 1966	
22a. SIGNATURE Carl J. Houmann		22c. PHYSICIAN'S NAME (Type) Carl J. Houmann, M. D.	
22d. ADDRESS Riverdale, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF MAR. 21 1966		23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEM.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD.		23d. LOCATION (city, town or county) (State) BLADENSBURG MD.	
		25a. REC'D BY REGISTRAR MAR 23 1966	
		25b. REGISTRAR'S SIGNATURE j Charles Judge	



1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04187

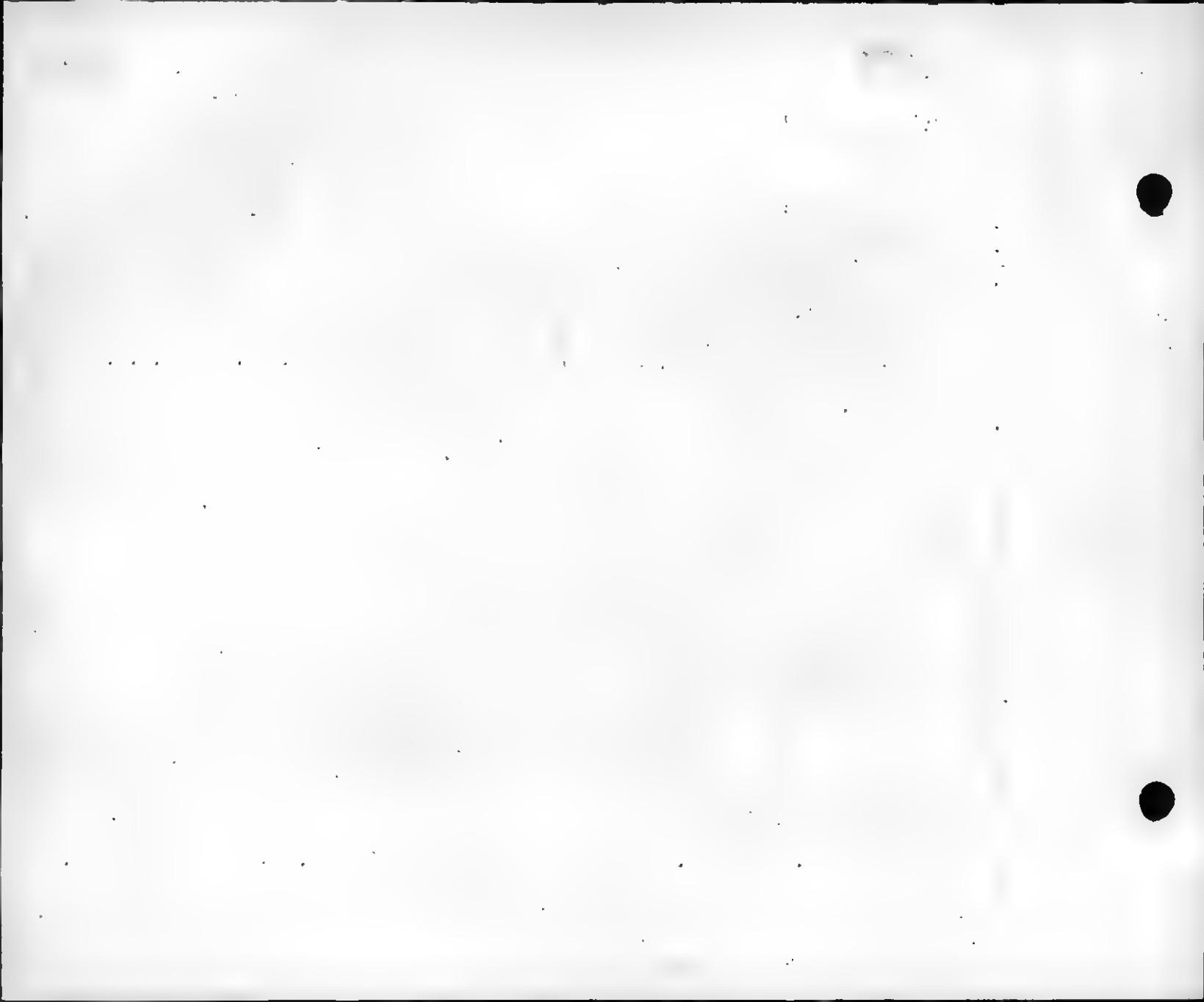
## CERTIFICATE OF DEATH

04177

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>16 hours</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>5817 Seminole Street</b>			
3. NAME OF DECEASED (Type or print)	First <b>Patrick</b>	Middle <b>Thomas</b>	Last <b>Gladding</b>		
4. DATE OF DEATH <b>March 2 1966</b>	Month Day Year	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>		
7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <b>OIVORCEO</b>	8. DATE OF BIRTH <b>5/15/1940</b>	9. AGE (In years last birthday) <b>25 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Pub School</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Accomack County, Va.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Harold F. Gladding</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Fontaine</b>	Address <b>Hospital Records</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. 	17. INFORMANT <b>Subarachnoid Hemorrhage</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		
INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Accomack County</b>	(County) <b>Accomack County</b>	(State) <b>Va.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>2 MARCH 1966</b> , to <b>2 MARCH 1966</b> that (I) (we) last saw the deceased alive on <b>2 MARCH 1966</b> , and that death occurred at <b>4:20 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert A. Mendelsohn</b>	22b. DATE SIGNED <b>2 March 66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert A. Mendelsohn</b>	22d. ADDRESS <b>1015 Spring St., Silver Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>3-3-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Lillston Funeral Home</b>	23d. LOCATION (City, town or county) <b>Accomack County</b>	(State) <b>Va.</b>	
24. FUNERAL DIRECTOR <b>J. Kaschi Sons Hagerstown, Md.</b>	ADDRESS <b>J. Kaschi Sons Hagerstown, Md.</b>	25a. REC'D BY REGISTRAR <b>John E. H. S.</b>	25b. REGISTRAR'S SIGNATURE <b>J. Kaschi</b>		



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

Item 7 19-10-67  
04188 04178

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OXON HILL</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OXON HILL</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6515 CIRCLE DRIVE</b>		d. STREET ADDRESS <b>6515 Circle Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>EDNA</b>	Middle <b>Nancy</b>	Last <b>GOFFE</b>
4. DATE OF DEATH <b>3-22-1966</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 9, 1893</b>
9. AGE (in years last birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <b>7</b>	11. IF UNDER 24 HRS. <input type="checkbox"/> Days <b>1</b>	12. IF UNDER 24 HRS. <input type="checkbox"/> Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>OHIO</b>	12. CITIZEN OF WHAT COUNTRY? <b>4-5</b>
13. FATHER'S NAME <b>JOHN STRATTON</b>	14. MOTHER'S MAIDEN NAME <b>MARY HUTCHINGS</b>	Address <b>MARY J. DOUGAN 6514 CIRCLE DR OXON HILL MD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>037-12-01230</b>	17. INFORMANT <b>MARY J. DOUGAN</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COLON CANCER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>COLON CANCER</b> DUE TO Underlying cause of death <b>COLON CANCER</b> DUE TO Underlying cause of death <b>COLON CANCER</b> INTERVAL BETWEEN ONSET AND DEATH <b>24H.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>	20f. (City or town) (County) (State) <b>BELTWOOD MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 23, 1966</b> , to <b>Mar 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 23, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.	22b. DATE SIGNED <b>Mar 28, 1966</b>		
22a. SIGNATURE <b>Herbert Wisotsky</b>	22b. ADDRESS <b>1001 Audrey 1A, OXON HILLS, MD.</b>	22d. ADDRESS <b>1001 Audrey 1A, OXON HILLS, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-24-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>WASHINGTON NATIONAL</b>	23d. LOCATION (City, town or county) (State) <b>BELTWOOD MD</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS 517 WEST 56</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

M

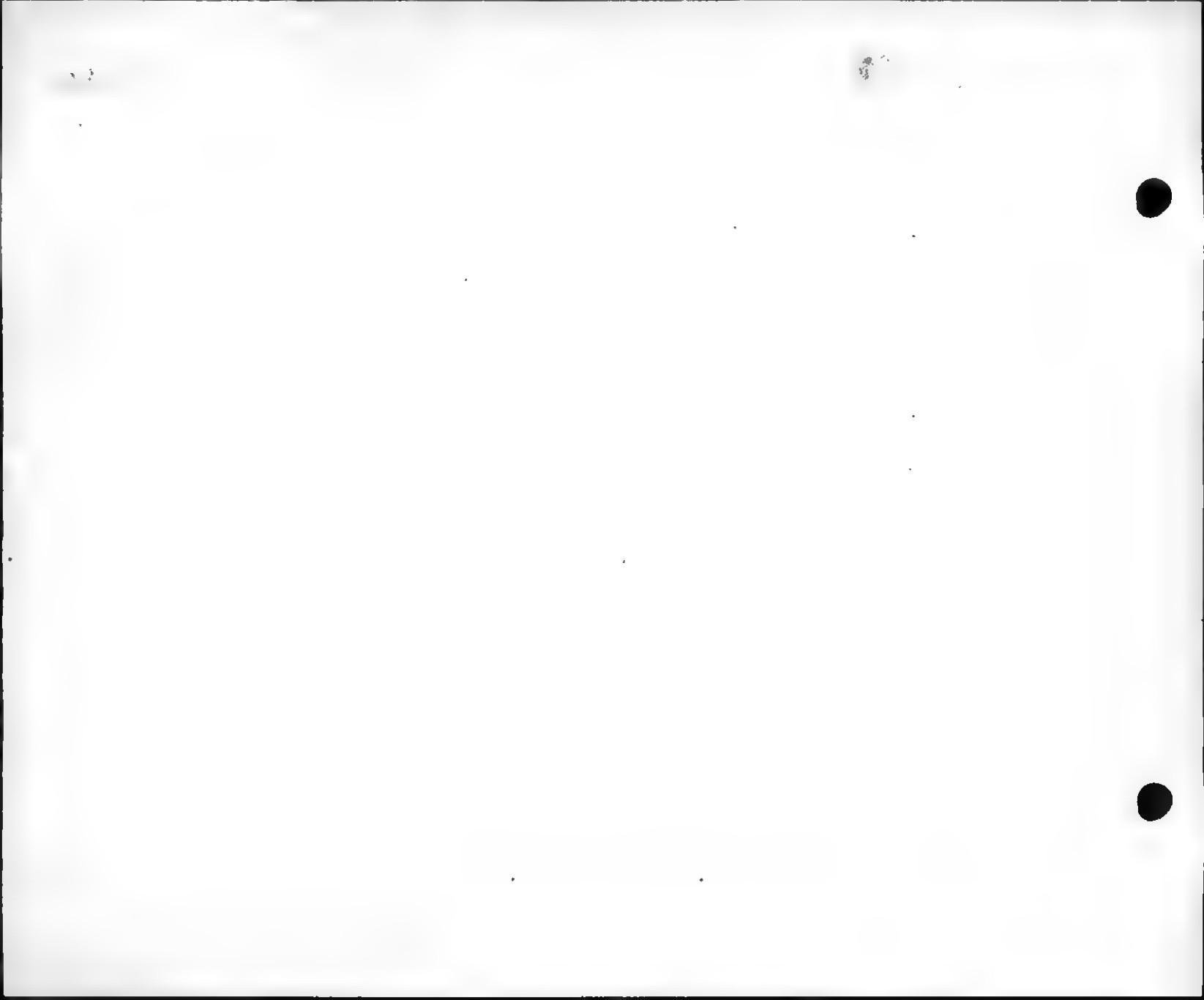
04189

04180

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)  Cheverly	c. LENGTH OF STAY IN Tb  DOA	b. COUNTY  Prince George's	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Lanham
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Prince George General Hospital		d. STREET ADDRESS  9619 Annapolis Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First AMOS	Middle EDWARD	4 DATE OF DEATH 3 15 19 66
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	8 DATE OF BIRTH 9-23-1881
9 NEVER MARRIED <input type="checkbox"/>	10b KIND OF BUSINESS OR INDUSTRY 45. Govt	10c DIVORCED <input type="checkbox"/>	11. BIRTHPLACE (State or foreign country) Virginia
12 AGE (In years last birthday) 81 yrs.	13. FATHER'S NAME Amos Goode	14. MOTHER'S MARRIED NAME Unknown	15. CITIZEN OF WHAT COUNTRY? U.S.A.
16 SOC. SECURITY NO No	17 INFORMANT 220-28-5938 Estelle Goode Same as 23	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
22. DATE SIGNED 3-16-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) 13-18-66		23b. DATE THEREOF 13-18-66	23c. NAME OF CEMETERY OR CREMATORIAL Haley Family
23d. LOCATION (City or Town) Woodmore Md		(County) (State)	
24. FUNERAL DIRECTOR 45. Washington & Sons 4925 Dean Ave		25a. ADDRESS 4925 Dean Ave	25b. RECEIVED BY REGISTRAR MAR 21 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.M  
04190

04181

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		d. COUNTY <b>Riverdale</b>	
c. LENGTH OF STAY IN 1b <b>1/1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES LOUIS GRAEFFE Sr.</b>			
First <b>CHARLES</b>		Middle <b>LOUIS</b>	Last <b>GRAEFFE Sr.</b>
4. DATE OF DEATH <b>March 20, 1966</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 7, 1883</b>	
WIDOWED <input type="checkbox"/>		9. AGE (in years last birthday) <b>82 yrs.</b>	
DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY <b>Union Iron Works</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rudolph Graefe</b>		14. MOTHER'S MAIDEN NAME <b>Lena Dahl</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 10 6890</b>	
17. INFORMANT <b>Daisy R. Graefe Same as #2 (wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung C</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastasis to Spine - Chest</i> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> , 19 <b>66</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>3/20</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>A Deitz</i>		22b. DATE SIGNED <b>3-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M.D.</b>		22d. ADDRESS <b>Prince George Plaza Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/23/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M  
FOR STATE  
HEALTH DEPT.

04191

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04183

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal; and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived) f. institution Residence before admission a. STATE <b>Md.</b>		Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b>		d. STREET ADDRESS <b>Alpine St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Br oks</b>		First <b>Nolan</b>	Middle <b>Greathouse</b>	Last <b>Greathouse</b>	4 DATE OF DEATH <b>2 April 1930</b>	Month <b>3</b>	Day <b>4</b>	Year <b>19 66</b>	
S SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>2 April 1930</b>	9 AGE (In years last birthday) <b>35 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. ARMY</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>OHIO</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>BROOKS NOLAN GREATHOUSE</b>		14. MOTHER'S Maiden Name <b>IVA BOLES</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown) <b>YES</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>7801 Alpine St. Dist. Height Mrs. Iva B. Greathouse Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5870</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)		Acute pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH Minutes					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Pancreatitis and cirrhosis of liver over 2 yrs							
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		20c. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20d. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or item 18)			
20e. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20f. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20h. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above and held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Ravenna, OHIO</b>		22. DATE SIGNED <b>3-6-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/8/66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>HOLLYWOOD MAPLE GROVE CEM.</b>		23d. LOCATION (City or Town) <b>Ravenna, OHIO</b>			
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS</b>		25a. REC'D BY REG STRR <b>MAR 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Kehoe, M.D.</b>					

ξ

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

M

04192

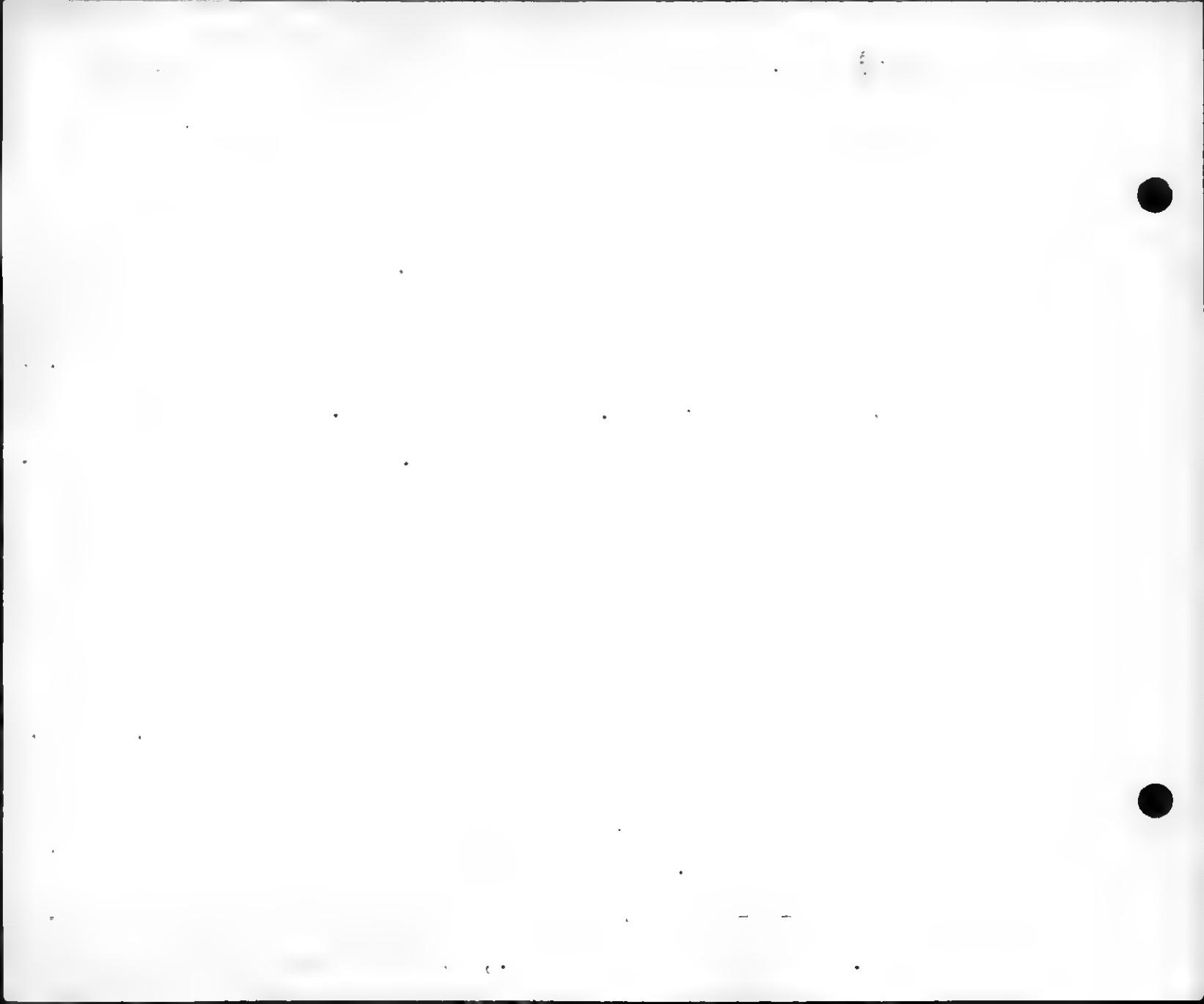
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04184

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**10 FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS 16		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3 NAME OF DECEASED (Type or print) James		First James	Middle Leo	Last Greer, Jr.	4 DATE OF DEATH March 26 1966	Month March	Day 26	Year 1966
5 SEX male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	NEVER MARRIED DIVORCED	8 DATE OF BIRTH 3-18-39	9 AGE (in years less birthday) 75 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a JUSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Trnder		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME James Leo Greer, Sr.				14. MOTHER'S MAIDEN NAME Bessie E. Douglass				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Regina F. Greer Upper Marlboro, Md.		Address		
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO lost. (c)		Gunshot wounds of chest				INTERVAL BETWEEN ONSET AND DEATH minutes		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot during altercation in bar.				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c TIME OF INJURY Month, Day, Year Hour, a.m. 10:00 P.M. 3-26-66		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Name, farm, factory, street, office, bldg, etc) Summit Inn		20f (City or town) (County) (State) Upper Marlboro P.G. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-27-66		
EXAMINER'S NAME (Type) John Kehoe, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3-31-66		23c NAME OF CEMETERY OR CREMATORIAL Arlington, National		23d LOCATION (City or Town) (County) (State) Arlington Va.		
24 FUNERAL DIRECTOR Myrtle K. Rollins		ADDRESS 4339 Hunt Pl., N.E.		25a REC'D BY REGISTRAR MAR 31 1966		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



1 M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

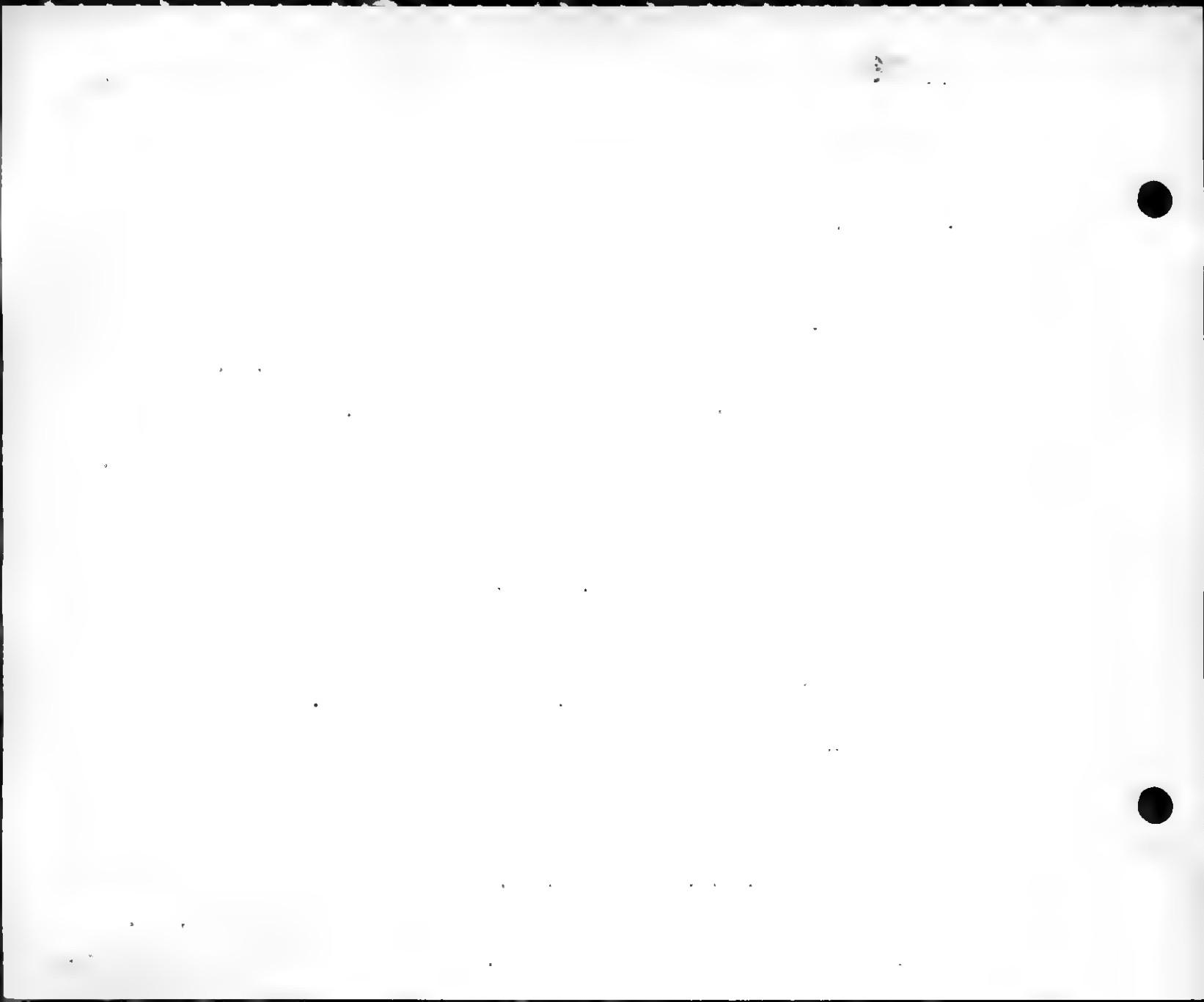
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04185

1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
a. COUNTY	Prince George's MARYLAND	a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN b. Cheverly 18 days	b. Maryland	Prince George's
c CITY OR TOWN (If auto de corporate limits, write RURAL and give nearest town)	c. East Pines /6 - 1		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS		
Prince George General Hospital	6304 Powhatan Street		
e IS RESIDENCE ON A FARM?	e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First: Donna	Middle: Hagerty	Last: 3 74 1966
S. SEX	6 COLOR OR RACE	7 MARRIED	8 NEVER MARRIED <input checked="" type="checkbox"/>
Female	White	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>
9. DATE OF BIRTH		10. AGE (in years last birthday)	
4-12-1961		4 yrs	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Washington D. C.		USA	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Donald K. Hagerty			Arlene M. King
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	none	Donald K. Hagerty	East Pines Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Broncho pneumonia, bilateral with abscess formation			
DUE TO			
9160 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)			
DUE TO 2nd and 3rd. degree burns of 46.3% of body surface (c)			
18 days			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
Clothing caught fire in the home.			
20c. TIME OF INJURY Month, Day, Year Hour am 9:30am p.m. 2-25-1966		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) Home
		20f. (City or town) Same as 22	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 17, 1966	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery
23d. LOCATION (City or Town) Colmar Manor, Md.		(County) (State)	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REGD BY REGISTRAR MAR 21 1966
			25b. REGISTRAR'S SIGNATURE 



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04186

M  
04194

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. **PAGE 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's County</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berwyn Heights</b>		c. LENGTH OF STAY IN MD <b>17 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5600 Ruatan Street</b>		e. STREET ADDRESS <b>5600 Ruatan Street</b>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		4. DATE OF DEATH Month Day Year <b>3 - 24 - 1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc.</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-13-1880</b>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or Foreign country) <b>Columbia, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stanley Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Endra Holland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of serv. <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MIRTIE S. HALEY</b>		18. CRUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Influenza.</b> DUE TO Conditions, if any, which gave rise to immediate cause } (b) (a), stating the underlying cause last, } DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING L OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (This hospital) attended the deceased from <b>9-1-59</b> , 19..., to <b>3-24-66</b> , 19..., that (I) (We) last saw the deceased alive on <b>3-23-66</b> , 19..., and that death occurred at <b>10:20 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>William B. Gunther</i>		22b. DATE SIGNED <b>3-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>William B. Gunther, M. D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>28 MARCH 1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Hart Lincoln Cemetery, Riverdale, Maryland</b>		23d. LOCATION (City, town or county) <b>Bladensburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>		25a. REC'D BY REGISTRAR DATE <b>Charles Judge MAR 28 1966</b>	



TO HOSPITAL  be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR  After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place ~~in~~ ~~on~~ ~~in~~ ~~on~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. H. E. H. E.  
Deputy Medical Examiner  
Burial

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05195

14187

1. PLACE OF DEATH

a. COUNTY

Prince George

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Riverdale

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6209 Beale Circle

3. NAME OF  
DECEASED  
(Type or print)

Howard

First

MARYLAND

c. LENGTH OF STAY IN HOSPITAL

2 years

5. SEX

M

6. COLOR OR RACE

W

Middle

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

6 Oct. 1891

Last

Hall

Month

3

Dey

31

Year  
1966

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Photographer

10b. KIND OF BUSINESS OR INDUSTRY

Coast & Geologic Survey

9. AGE (In years last birthday)

74 yrs.

IF UNDER 1 YEAR

Months

Days

Hours Min.

13. FATHER'S NAME

Morgan Hall

14. MOTHER'S MAIDEN NAME

Anna Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  (Yes, no, or unknown) (If yes, give rank or date of service)

Yes

16. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c))

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

215-46-3323

James M. Hall Silver Spring, Maryland

14409 Marine Drive

Address

INTERVAL BETWEEN  
ONSET AND DEATH

Myocardial Infarction

Arterio Sclerotic heart disease

Green

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES  NO

Bundles Branch Block

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

While at work  Not While at work

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20e. (City or town)

(County,

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1961 to Dec. 1965, that (I) (we) last saw the deceased alive on Dec. 1965, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Dr. H. E. Weintraub

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Wm. Weintraub

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

2 April 1966

23c. NAME OF CEMETERY OR CREMATORIAL

Port Lincoln Cemetery

23d. LOCATION (City, town or county)

Prince Georges Co., Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Dean Carter 8434 Georgia Avenue

Warner E. Pumphrey, Inc. Silver Spring, Md.

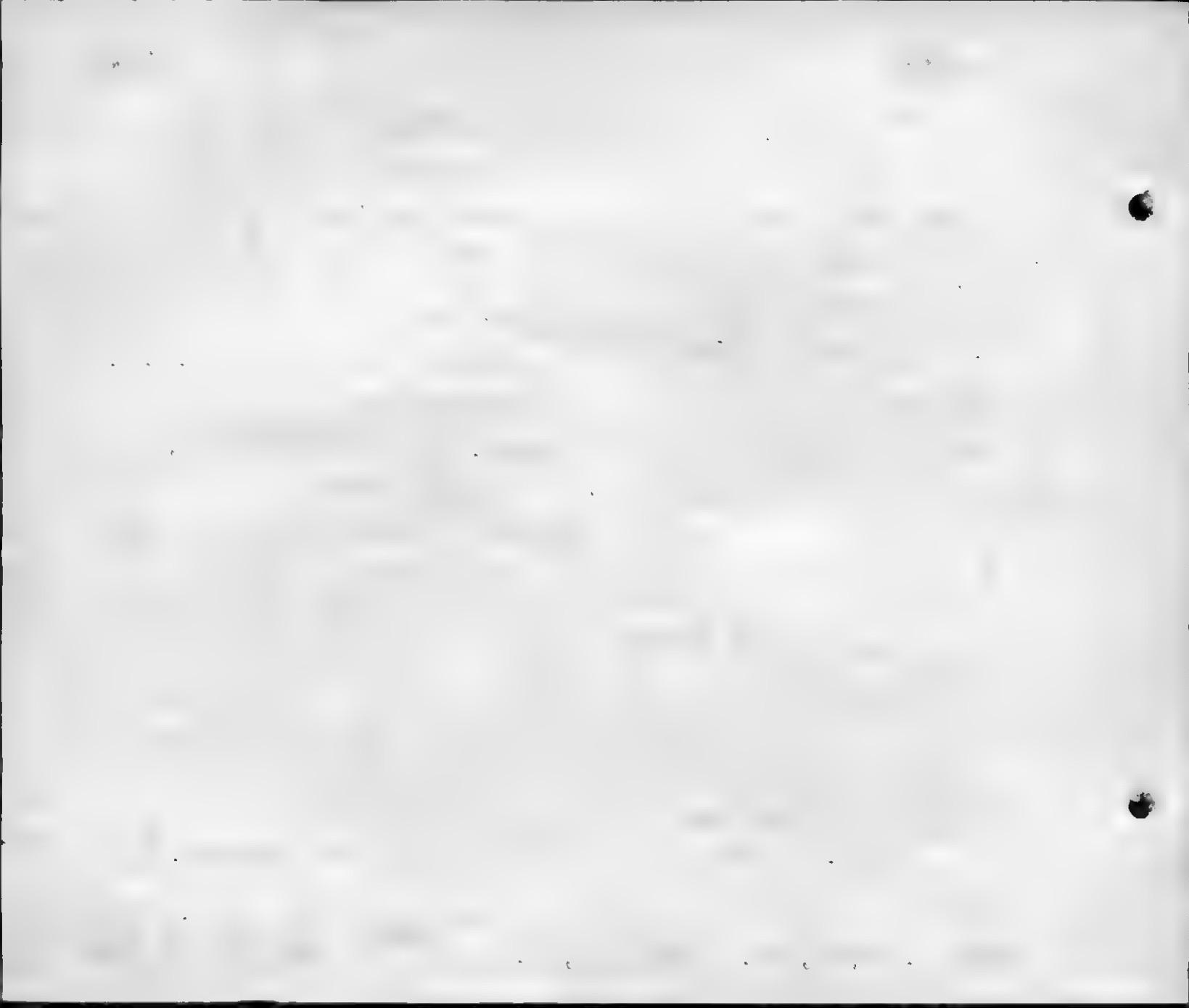
25a. SIGNED BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

APR 6 1966 Charles Judge

DATE

15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

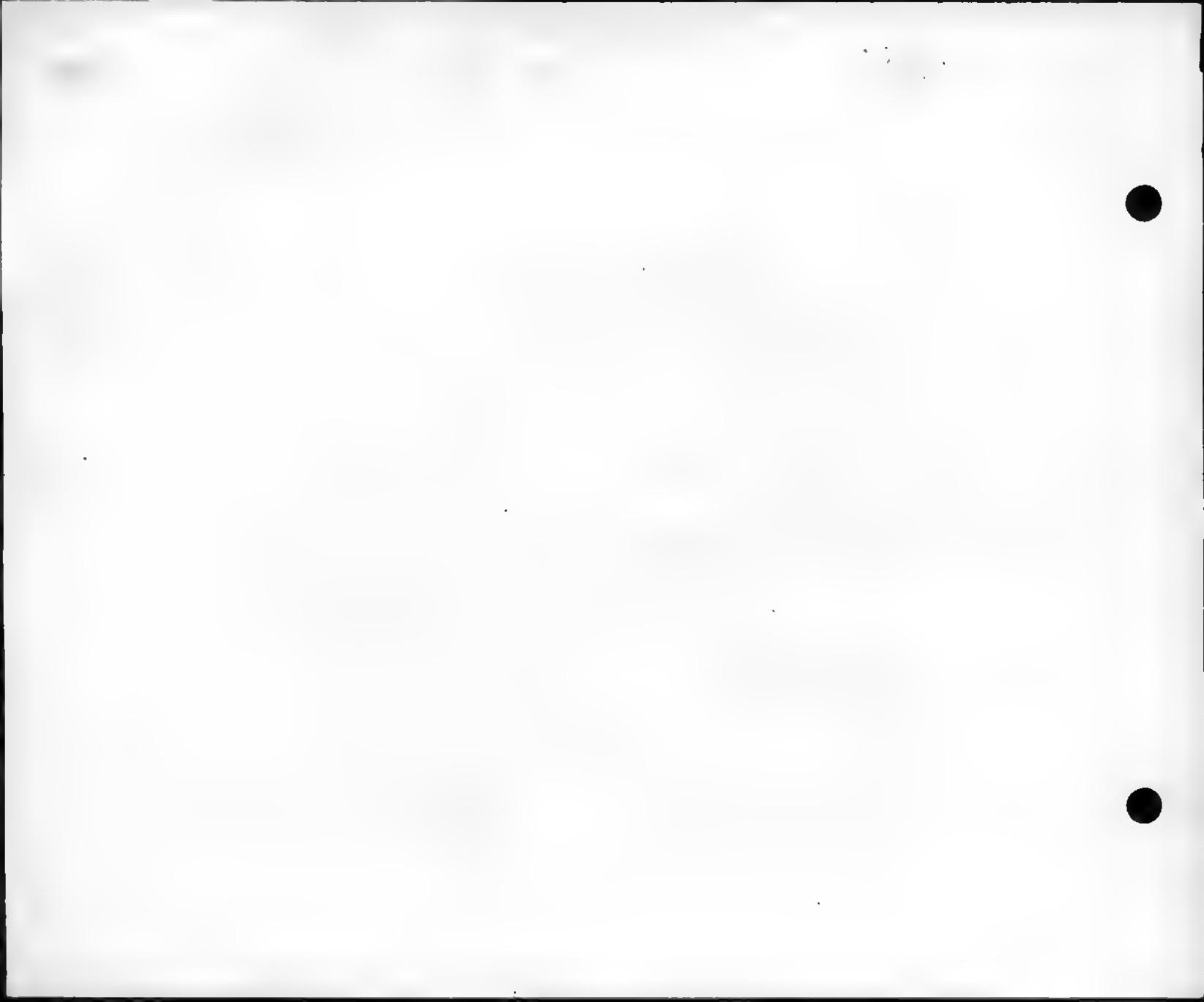
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05196

CERTIFICATE OF DEATH

04188

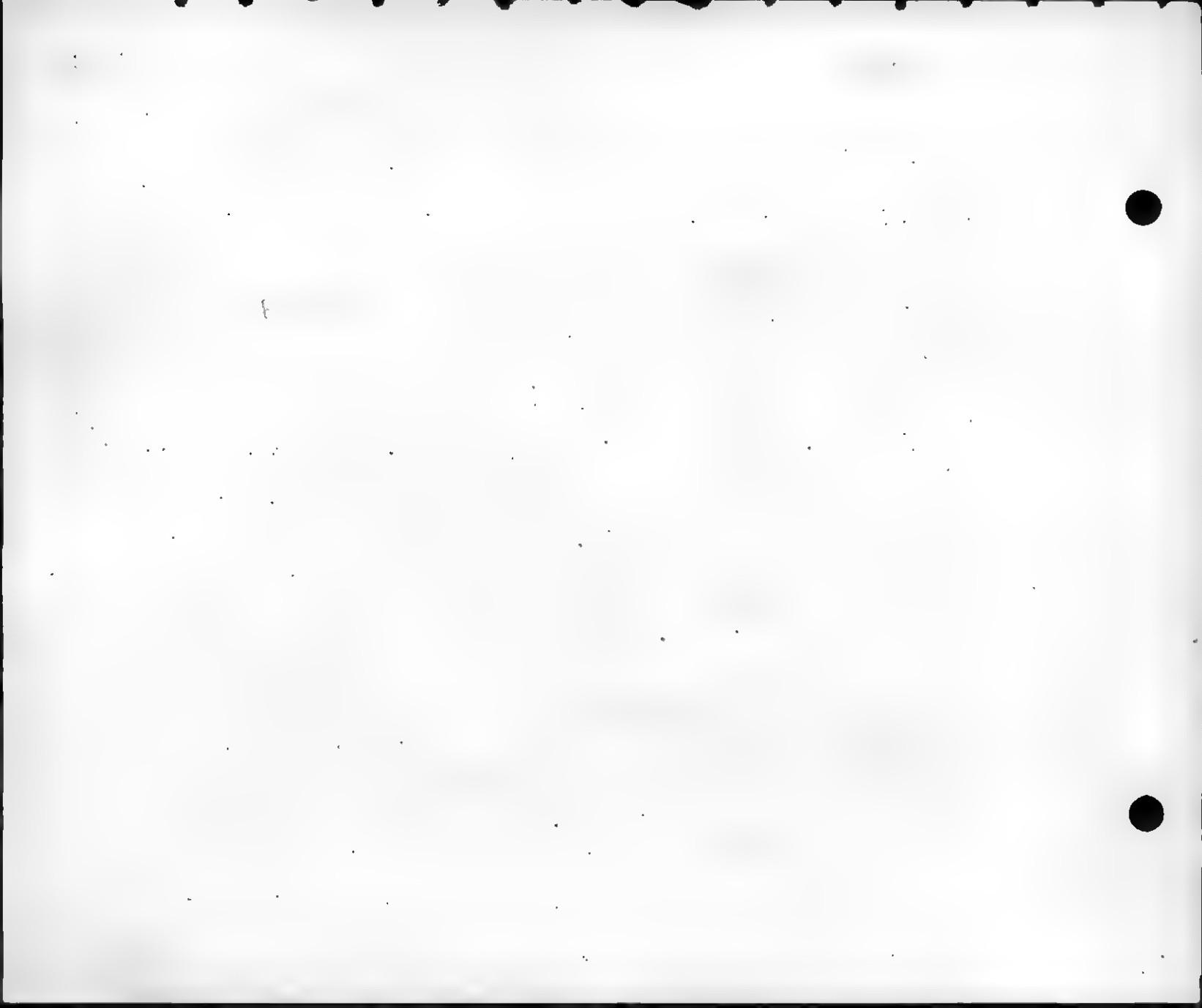
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
<i>Prince George</i> MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>Lanier</i>		<i>Pr. Geo.</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		<i>Lanier</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>1620 Sandy Spring Rd</i>		<i>1620 Sandy Spring Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>John</i>	<i>Davis</i>	<i>Hall</i>	
4. DATE OF DEATH	Month	Day	Year
	<i>March</i>	<i>28</i>	<i>1966</i>
5. SEX	c. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>m</i>	<i>w</i>	<i>WIDOWED</i> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>Feb 13 1891</i>
9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>75 yrs.</i>	<i>dairy farm</i>	<i>Maryland</i>	<i>USA</i>
13. FATHER'S NAME	14. MOTHER'S MADDEN NAME	Address	
<i>William S. Hall</i>	<i>Ella Brady</i>	<i>Campbell Ave. John E. Hall &amp; Son</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
<i>farmer</i>	<i>217-14-7746</i>	<i>John E. Hall &amp; Son</i>	<i>a. S.C.V.R.D.</i>
			<i>it is not</i> DUE TO <i>Cerebral Arteriosclerosis</i> <i>5 yrs</i>
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)		
	DUE TO		
	(c)	<i>Gen'l Arteriosclerosis</i>	<i>10 - yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Metabolic hypertension</i> <i>Blood clot obstruction</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
<i>19</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>2/13</i> , 19 <i>61</i> , to <i>3/28</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3/25</i> , 19 <i>66</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.	22a. SIGNATURE <i>J M Warren</i>	22b. DATE SIGNED <i>Jan 21 1966</i>	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <i>J M Warren</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<i>Burial</i>	<i>3-31-66</i>	<i>Meadowridge</i>	<i>Nest Park</i>
24. FUNERAL DIRECTOR	ADDRESS <i>DeWitt Danedon Lanier Md</i>	25a. REC'D BY REGISTRAR <i>APR 11 1966</i>	25b. REGISTRAR'S SIGNATURE <i>John L. Judge</i>



10 HOSPITAL OR ATTENDING PHYSICIAN The box requires at least one death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Parkers Corner</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>PA</i>				b. COUNTY <i>FRANKLIN</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lancaster</i>				c. LENGTH OF STAY IN 1b <i>2 mo</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chamberlain Bldg., PA</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Magnolia Garden Nursing Home</i>				d. STREET ADDRESS <i>32 W. Green St</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Charles</i>	Middle <i>J.</i>	Last <i>Haller</i>	4. DATE OF DEATH <i>March 14 1966</i>	Month	Day	Year	5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 17. 1882 83 yrs.</i>				9. AGE (In years last birthday) <input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mammoth Eng. Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Chamberlain Bldg.</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Chamberlain PA</i>			
13. FATHER'S NAME <i>FRANK B. HALLER</i>				14. MOTHER'S MAIDEN NAME <i>GRIECE ECKEL</i>				12. CITIZEN OF WHAT COUNTRY? <i>Address 12904 Bentley Ln, Bowie</i>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>175-03-1179</i>				17. INFORMANT <i>Mr Charles P. Haller, Bowie</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastro-intestinal hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). <i>(b) Metastatic carcinoma of stomach</i>				46 months							
DUE TO Cause (c) <i>(c) Carcinoma of prostate</i>				10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic arteriosclerosis and cerebral disease</i>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Marion, PA</i>		(County) <i>Franklin Co.</i>		(State) <i>PA</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Marion, PA</i> , to <i>17 March 1966</i> , that (I) (we) last saw the deceased alive on <i>15 March 1966</i> , and that death occurred at <i>PA</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John Cosma M.D.</i>				22b. DATE SIGNED <i>1966</i>							
22c. PHYSICIAN'S NAME (Type) <i>JOHN COSMA, M.D.</i>				22d. ADDRESS <i>3010 STONYBROOK DR. BOWIE, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>MAR 19 1966</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>NORLBURG Cemetery, PA</i>		23d. LOCATION (City, town or county) (state) <i>PA</i>	
24. FUNERAL DIRECTOR <i>Harold S. WADE, Laurel, Md.</i>				ADDRESS				25a. REC'D BY REGISTRAR DATE <i>MAR 23 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
04198  
04198  
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		d. STREET ADDRESS <b>7319 Keystone Lane, Apt. 202</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>												
3 NAME OF DECEASED (Type or print)		First <b>Catherine</b>	Middle <b>Louise</b>	Last <b>Hamilton</b>	4 DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>1966</b>							
5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>	7 MARRIED W DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>	8. DATE OF BIRTH <b>23 June 1906</b>		9 AGE (in years last birthday) <b>59 yrs</b>	10. UNDER 1 YEAR Months <b>59</b>	11. UNDER 24 HRS Days <b>0</b>	12. IF UNDER 1 YEAR Hours <b>0</b>	13. IF UNDER 24 HRS Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even part time) <b>Employed Waitress</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Business Restaurant</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Bernard Brady</b>				14. MOTHER'S MAIDEN NAME <b>Mary Alberta Fowler</b>				Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>212-20-1088</b>		17. INFORMANT <b>Margaret Marie Long-Same as Item #2</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b>								INTERVAL BETWEEN ONSET AND DEATH over 2 weeks				
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) From hypertensive arteriosclerotic heart disease				unknown				
DUE TO				DUE TO								
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Forestville</b>		(County) <b>Md.</b>		(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <b>3-11-66</b>				
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
Address (Street, city, town, or county)												
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/15/66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Epiphany Cemetery</b>		23d. LOCATION (City or Town) <b>Forestville</b>		(County) <b>Md.</b>		(State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>Ritchie Bros. Fun'l Home-Upper Marlboro</b>		ADDRESS <b>Md.</b>		25a. RECD BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						
DATE MAR 15 1966												

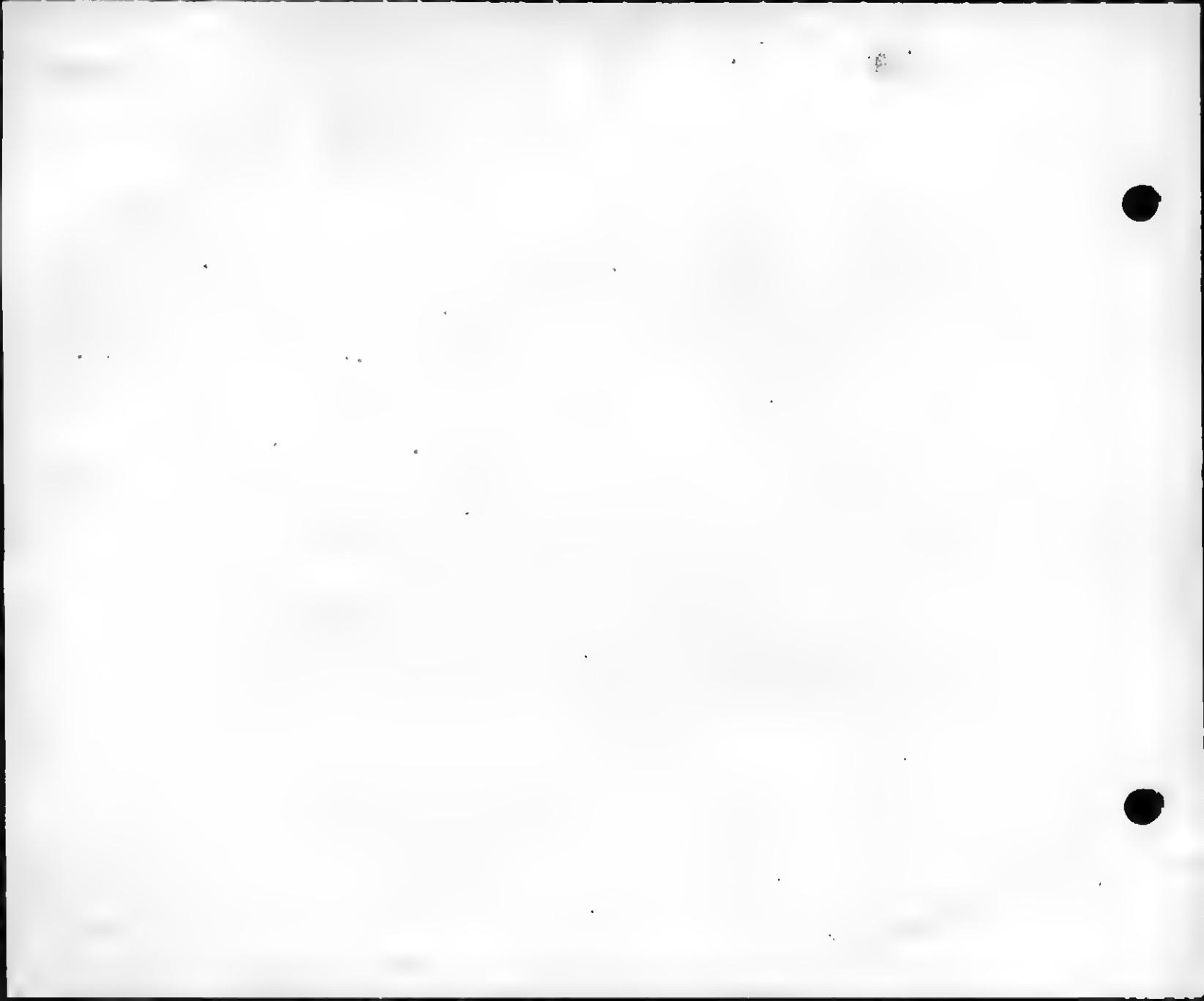
-03-

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HOSPITAL ATTENDANT  The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY  Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geor								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakcrest						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dakcrest								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308 Locust Street						d. STREET ADDRESS 308 Locust Street								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print)		First John	Middle J. Hansberry	Last	4. DATE OF DEATH Mar. 22, 1966	Month	Day	Year						
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1896	9. AGE (in years last birthday) 69 yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Nelson Co., Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Louis Hansberry	14. MOTHER'S MAIDEN NAME Betty Woody	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Viola C. Hansberry: Item # 2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mitastatic Carcinoma Prostate</i> 4 yrs DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma Prostate</i> 5 yrs DUE TO Underlying cause (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Neur. Arthritis &amp; Disparition</i>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Laurel	(County) Md.	(State) Md.								
21. I certify that (I) (this hospital) attended the deceased from <u>7/5/66</u> , 19 <u>66</u> , to <u>3/21/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/21/66</u> , 19 <u>66</u> , and that death occurred <u>3/21/66</u> AM, from the causes and on the date stated above.														
22a. SIGNATURE <i>J M Warren</i>														
22b. DATE SIGNED <i>Laurel, Md.</i>														
22c. PHYSICIAN'S NAME (Type) <i>J M Warren</i>		22d. ADDRESS <i>Laurel, Md.</i>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/26/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>CARVER Mem. Park</i>	23d. LOCATION (City, town or county) <i>LAUREL</i>	(State) <i>Md.</i>									
24. FUNERAL DIRECTOR <i>Robert L. Snowden Rockville, Md.</i>		ADDRESS <i>Kobert L. Snowden Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 28 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and/or any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY <b>Prince George</b>				a. STATE <b>Maryland</b> b. COUNTY <b>Prince</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>				c. LENGTH OF STAY IN 1D <b>17 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cheverly, Md.</b>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joel Gnegy</b>				First <b>C. J.</b>	Middle <b>Han</b>	Last <b>Gnegy</b>	4. DATE OF DEATH Month Day Year <b>19 1966</b>				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER 1 YEAR Months Days Hours Min. <b>yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>J.S.A.</b>					
13. FATHER'S NAME <b>Joel Gnegy</b>						14. MOTHER'S MAIDEN NAME <b>Virginia Mowery</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
						Olive Wisecarver			3508 79th Avenue		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> INTERVAL BETWEEN ONSET AND DEATH 203X DUE TO _____ Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>											
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
						19					
21. I certify that (I) (this hospital) attended the deceased from <b>3/5</b> , 19 <b>66</b> , to <b>3/22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/22</b> , 19 <b>66</b> , and that death occurred at <b>... M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Edwin J. Jensen</b>											
22b. DATE SIGNED <b>3/23/66</b>											
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-26-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b>					
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		ADDRESS <b>4308 Suitland Rd Suitland Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
VR A15 (4) 20M 1/65											



1 M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

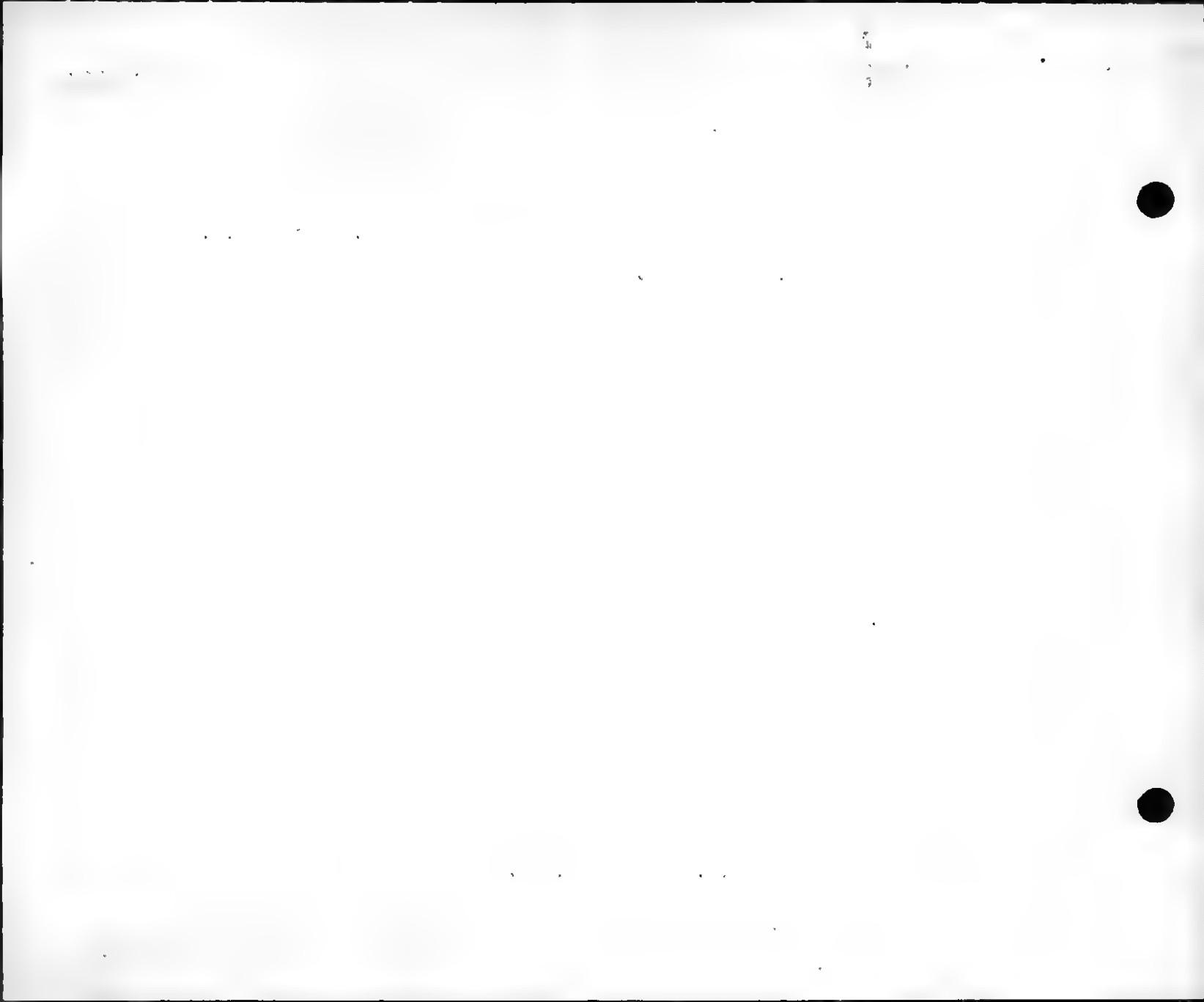
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04193

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Washington 41	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 1400 29th Street, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle R.	4. DATE OF DEATH Month 3 Year 28 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 1889 9. AGE (In years lost birthday) 76 yrs
10. JSUAL OCCUPATION (Give kind of work done during most of working life even if retired) Film Examiner		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Alexandria, Virginia	
13. FATHER'S NAME William Harvey		14. MOTHER'S MAIDEN NAME Frances	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Almeda H. Alt-5149-Nebraska Ave NW Wash DC		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure		INTERVAL BETWEEN ONSET AND DEATH minutes	
4200 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last		over 5 yrs.	
(b) Arteriosclerotic heart disease			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D'SEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 31-1966	
23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS 1361-Good Hope Rd SE Wash DC	
		25a. REC'D BY REGISTRAR MAR 30 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



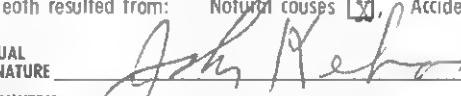
## MARYLAND STATE DEPARTMENT OF HEALTH

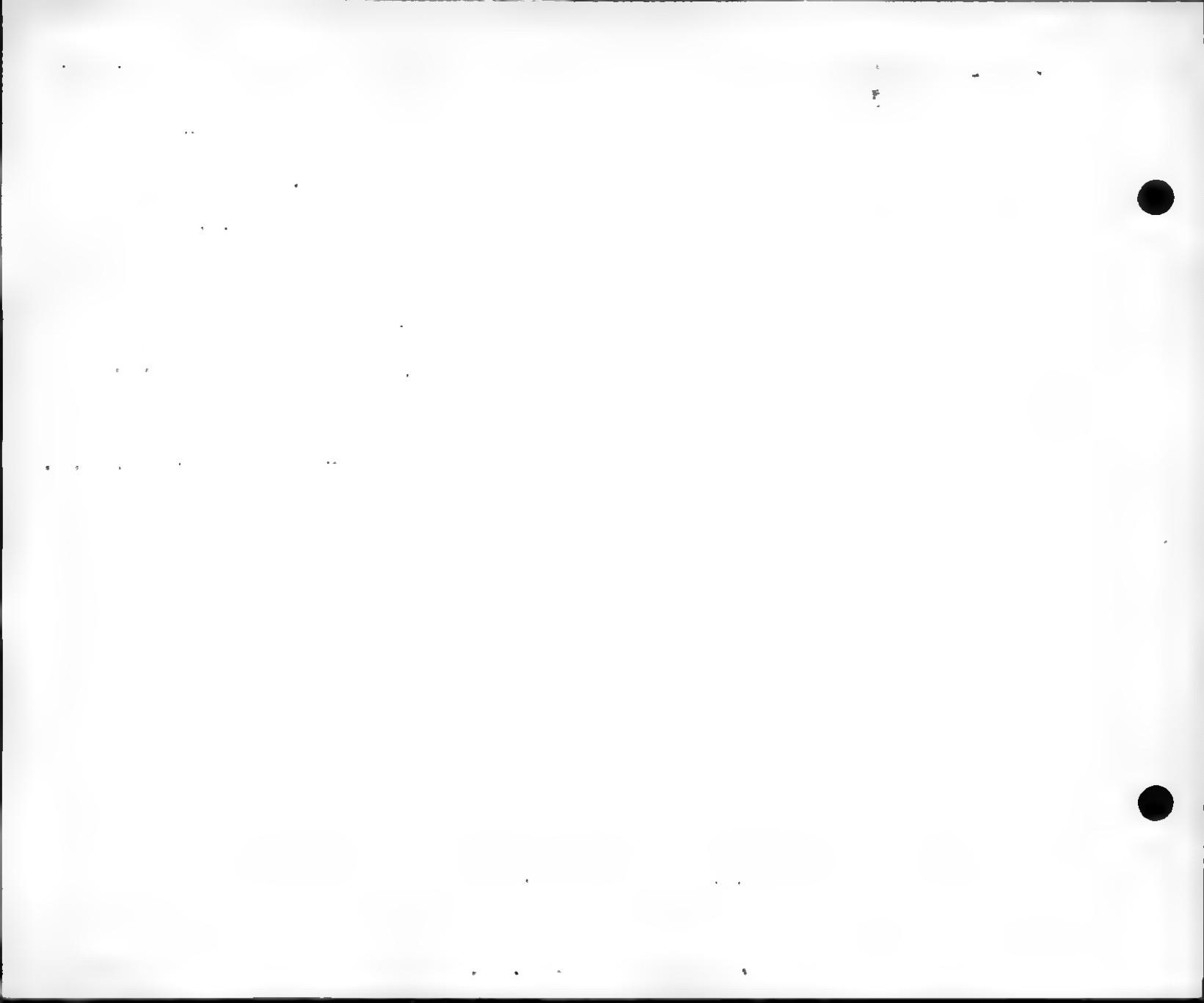
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

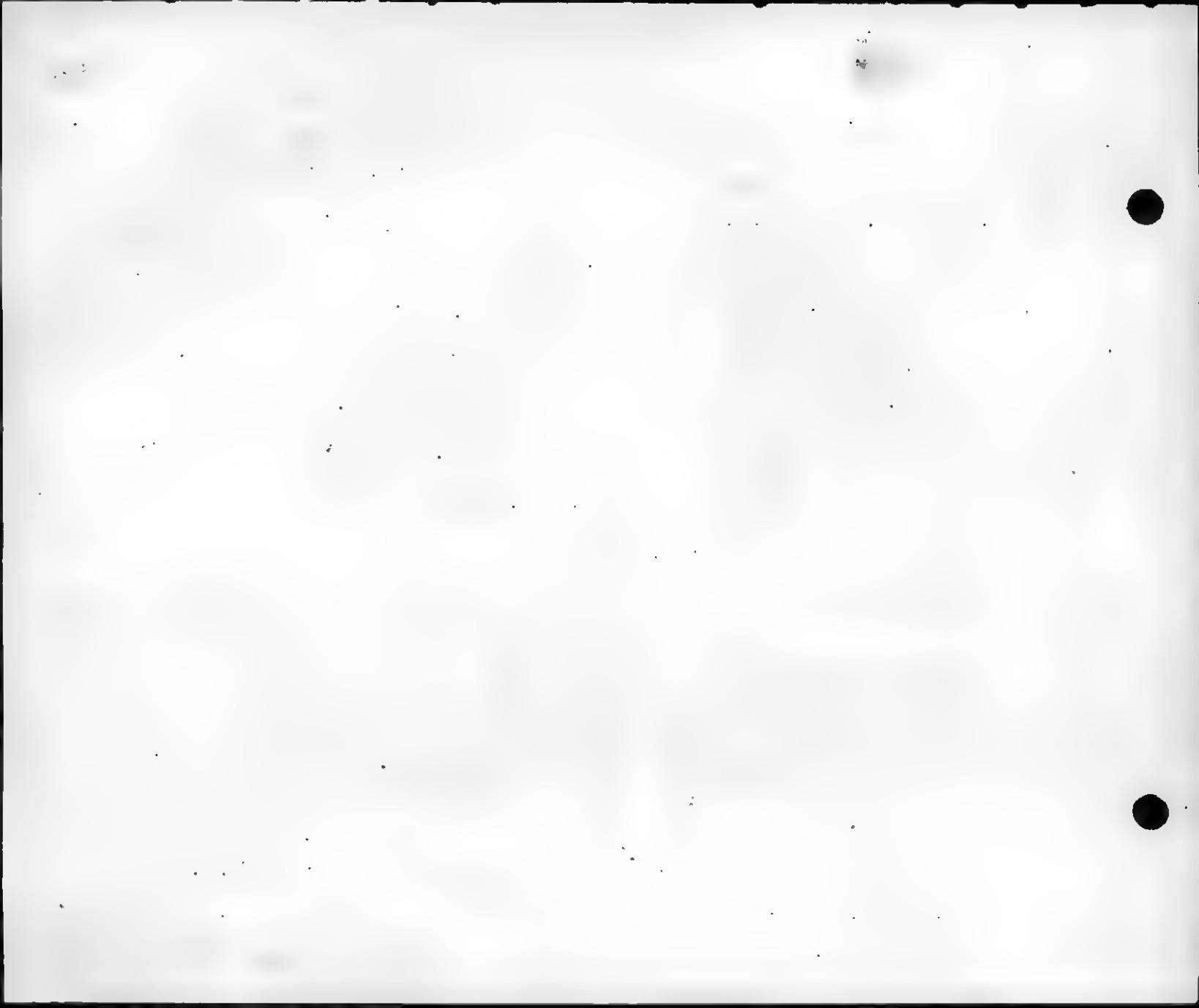
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04202				04194							
1. PLACE OF DEATH a. COUNTY Prince George's Maryland				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE - b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton DOA				c. LENGTH OF STAY IN lb - d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Maryland Hospital				d. STREET ADDRESS 764 Howard Street, S.E.			
3. NAME OF DECEASED (Type or print) Etta Beatrice Hatton				4. DATE OF DEATH Month 3 Day 18 Year 1966				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX female		6. COLOR OR RACE Negro		7. MARRIED WIDDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH March 29, 1910		10. AGE (In years lost birthday) 55 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister				10b. KIND OF BUSINESS OR INDUSTRY Church				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Salisbury Ford				14. MOTHER'S MAIDEN NAME Geneva Smith				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO None				16. SOCIAL SECURITY NO				17. INFORMANT Melvin Hatton - 764 Howard St., S.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 143X (b) Hypertensive Cardio-Vascular Disease DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  MD EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-23-66		23c. NAME OF CEMETERY OR CREMATORIUM Cemetery Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR John T. Rhines Co., Washington, D. C.				ADDRESS -				25a. REC'D BY REGISTRAR MAR 23 1956		25b. REGISTRAR'S SIGNATURE 	



HOSPITAL OR ATTENDING PHYSICIAN The law requires that the certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1 and 2) from the certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										04195	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY PRINCE GEORGE'S MARYLAND					b. STATE MARYLAND b. COUNTY PRINCE GEORGE'S						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB MARYLAND					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7723 WALTERS LANE						
c. LENGTH OF STAY IN 1b 13 HRS					d. STREET ADDRESS FORRESTSVILLE MARYLAND						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS										6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ANDREW	Middle JOHN	Last HAWKINS	4. DATE OF DEATH MARCH 6 19 66		Month	Day	Year		
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5 MAR 66		9. AGE (In years last birthday) yrs. 13 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10b. KIND OF BUSINESS OR INDUSTRY N/A			11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S MD, USA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME PAUL E. HAWKINS					14. MOTHER'S MAIDEN NAME MARJORY L. BLISS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A			16. SOCIAL SECURITY NO. N/A			17. INFORMANT PAUL E. HAWKINS, SAME AS #2			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure										INTERVAL BETWEEN ONSET AND DEATH 12 Hrs	
7. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) Prematurity					12 Hrs	
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (X) (this hospital) attended the deceased from 5 Mar 19 66 to 6 Mar 19 66, that (X) (we) last saw the deceased alive on 6 MAR 19 66, and that death occurred at 1230 M, from the causes and on the date stated above.										22b. DATE SIGNED 6 MAR 1966	
22a. SIGNATURE Roger E. Spitzer, CAPT					22b. DATE SIGNED 6 MAR 1966						
22c. PHYSICIAN'S NAME (Type) ROGER E. SPITZER, CAPT, MC, USAF					22d. ADDRESS USAF Hospital Andrews, Andrews AFB, Wash D.C. 20331						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL March 10, 1966 Arlington National					23c. NAME OF CEMETERY OR OREMATORIAL					23d. LOCATION (City, Town or County) Arlington, Virginia (State)	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO.					ADDRESS 5711 WESTSE Wash. D.C.					25a. REC'D BY REGISTRAR MAR 10 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



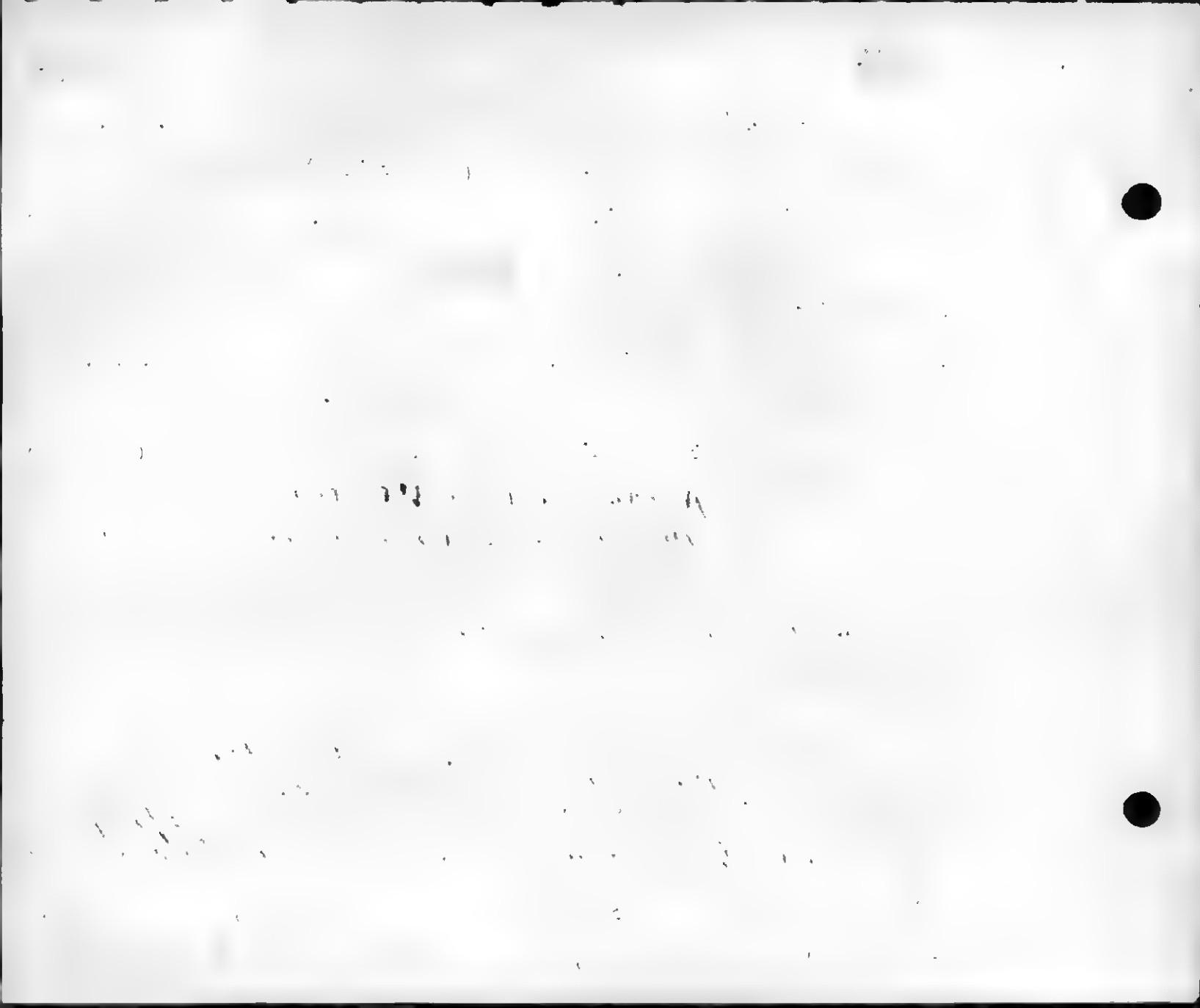
## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04196

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.		2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1B <b>3mos. 22das</b>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>( Hyattsville ) Villa Heights</b>		d. STREET ADDRESS <b>3909 57th Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Adele C. Herrmann</b>		4. DATE OF DEATH Month <b>March 17 1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <b>WIDOWED</b>		8. DATE OF BIRTH <b>11-11-1889</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 0 0 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing Co.</b>	
11. BIRTHPLACE (Country & State or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henri Croissant</b>		14. MOTHER'S MAIDEN NAME <b>Camille Racine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579 28 5417A</b>	
17. INFORMANT <b>Minnie E. Nuthall Same as #2 (daughter)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Aneurysm LEFT VENTRICLE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>Myocardial Infarction</b>		<b>2 1/2 mos</b>	
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Canceroma of Rectum</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1960</b> to <b>3/17 1966</b> that (I) (we) last saw the deceased alive on <b>3/17 1966</b> and that death occurred at <b>10:15 p.m.</b> M. from the causes and on the date stated above.		22b. DATE SIGNED <b>3/18/66</b>	
22a. SIGNATURE <b>Norman J. Comeau</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.C.P. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Norman J. Comeau</b>		22d. ADDRESS <b>3503 Pennyst Mtn (Annie M.)</b>	
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE THEREOF <b>3/21/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 21 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE								
Prince George Maryland			Md								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			b. COUNTY Pr. Geo.								
c. LENGTH OF STAY IN lb Laurel 3 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Laurel General Hospital 417 German Line								
3. NAME OF DECEASED (Type or print)			First Tiller	Middle J	Last Hill	4. DATE OF DEATH	Month March	Day 14	Year 1966	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 27 1879		9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. US OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY lawyer			11. BIRTHPLACE (County & State, or foreign country) US Government Bustamsville Md			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edwin C. Hill			14. MOTHER'S MAIDEN NAME Anna Kittle								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, No, or Unknown)			16. SOCIAL SECURITY NO. no			17. INFORMANT R. E. Ray Danielson, Laurel Md			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Hypertension - (c) Gen'l Arteriosclerosis											
INTERVAL BETWEEN ONSET AND DEATH 1 day 10 days 10 yrs 10 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Gastitis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/15/1966 to 3/14/1966, that (I) (we) last saw the deceased alive on 3/14/1966, and that death occurred at 9 P.M. from the causes and on the date stated above.											
22a. SIGNATURE J. M. Warren			22b. DATE SIGNED 3/14/66								
22c. PHYSICIAN'S NAME (Type) J. M. WARREN			M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-17-66			23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery			23d. LOCATION (City, town or county) Bustamsville Md		
24. FUNERAL DIRECTOR DeWitt Danielson, Laurel Md			ADDRESS			25a. REC'D BY REGISTRAR MAR 22 1956			25b. REGISTRAR'S SIGNATURE Charles Judge		
B6											



**HOSPITAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
04206				04198									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <b>Virginia</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 hr. 35 min.</b>				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. STREET ADDRESS <b>1950 Kidwell Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Baby</b>	Middle <b>Girl</b>	Last <b>Hirl</b>	4. DATE OF DEATH Month <b>March</b>	Month <b>24</b>	Day <b>1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1966</b>	9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS <input type="checkbox"/>	Months <b>1</b>	Days <b>35</b>	Hours <b>1</b>	Min. <b>35</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Peter Hirl</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Ellen McLenora</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <b>--</b>				17. INFORMANT Address <b>Mother</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				DUE TO <i>Brewmather by</i>									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO <i>premature labor</i>									
DUE TO <i>premature labor</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>					
21. I certify that (I) <del>attended</del> attended the deceased from <b>March 24, 1966</b> to <b>March 24, 1966</b> , that (I) <del>saw</del> last saw the deceased alive on <b>March 24, 1966</b> , and that death occurred at <b>9:45</b> M, from the causes and on the date stated above.												22b. DATE SIGNED <b>3-24-66</b>	
22a. SIGNATURE <i>Milos A. Jansa</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>3-24-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Milos A. Jansa</b>				22d. ADDRESS <b>7403 Varnum St. Landover Hills, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/29/66</b>				23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Natl. Cemetery, Arlington, Va.</b>				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Jos. T. Ryan, Inc. 317 Pa. Av., Ste. DC3</b>				ADDRESS <b>ADDRESS</b>				25a. REC'D BY REGISTRAR <b>MAR 30 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

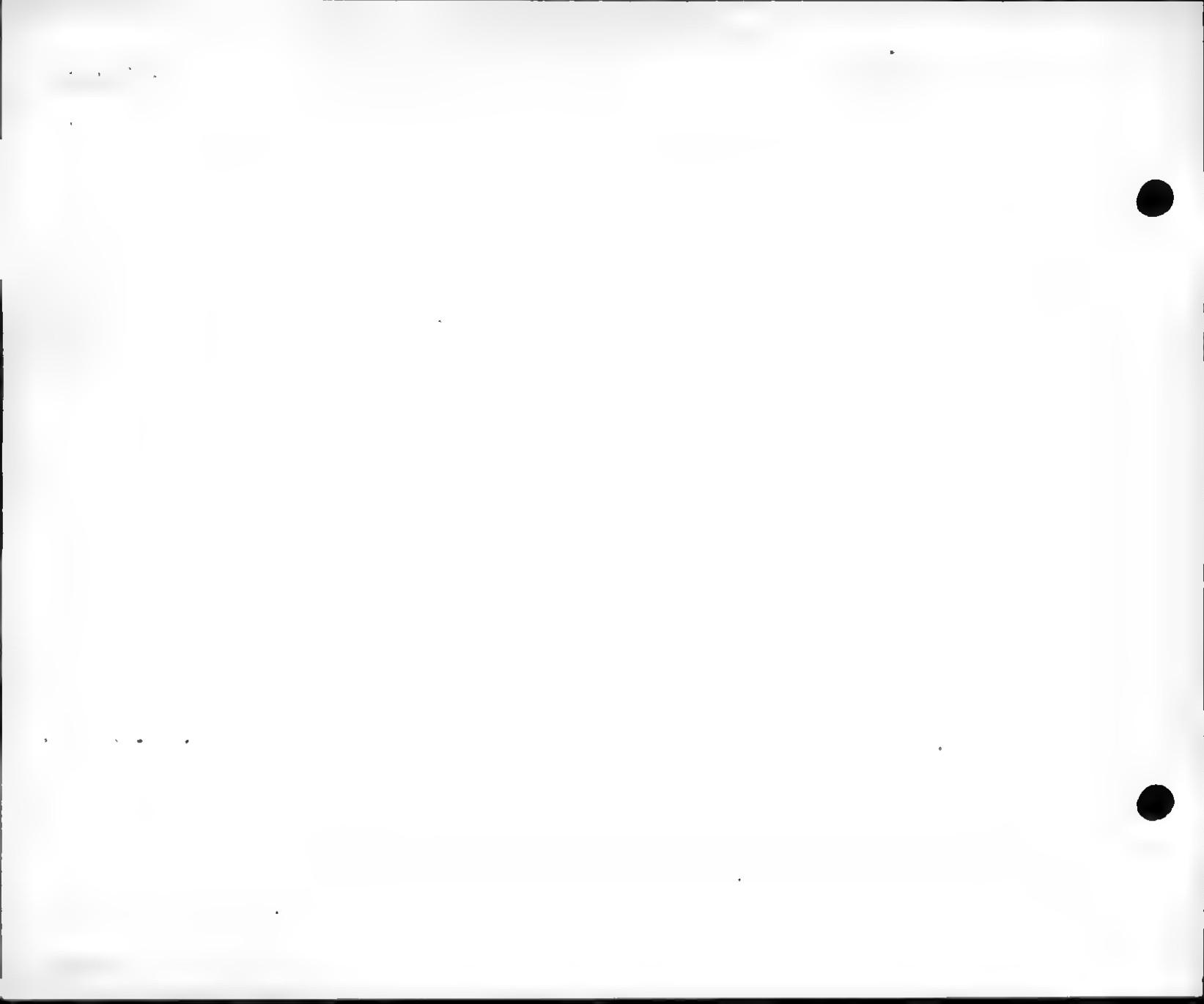
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04-207

04-199

1 PLACE OF DEATH a COUNTY Prince George's		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson Heights		c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson Heights			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6602 K Street		d STREET ADDRESS 6602 K Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary		Middle Lena		4. DATE OF DEATH Holmes 3 12 1966		Month Day Year	
S SEX female	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> D VDRCED <input type="checkbox"/>	8 DATE OF BIRTH 11-7-29	9 AGE (In years last birthday) 36 yrs	IF UNDER 1 YEAR Months Address	IF UNDER 24 HRS. Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Pa		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Henry Waddell		14 MOTHER'S MAIDEN NAME Elizabeth Dickerson					
15 WAS DECEASED EVER IN JS ARMED FORCES (Yes, no, or unknown) _____		16 SOCIAL SECURITY NO		17 INFORMANT Henrietta Thomas 4536 Dup St, N.E.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and Shock 982 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost (b) Laceration of liver and DUE TO (c) Multiple lacerations of head and body						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) beaten and cut by assailant		20c PLACE OF INJURY (name, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Jefferson Hts. P.G. Md.	
20e TIME OF INJURY Month, Day, Year Hour a.m. ab. 3:00PM 3-12 1966		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> John Kehoe M.D. MD		22. DATE SIGNED 3-13-66	
ACTUAL SIGNATURE <i>John Kehoe</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Medical Examiner <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				Address (Street, city, town, or county) Henry S. Washington Blvd. 4925, Nene Ave, N.E.			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE THEREOF 3-16-1966		23c NAME OF CEMETERY OR CREMATORIUM Lincoln Mem Cemetery Suitland, Md.		23d LOCATION (City or Town) (County) (State) Suitland, Md.	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR MAR 18 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1M

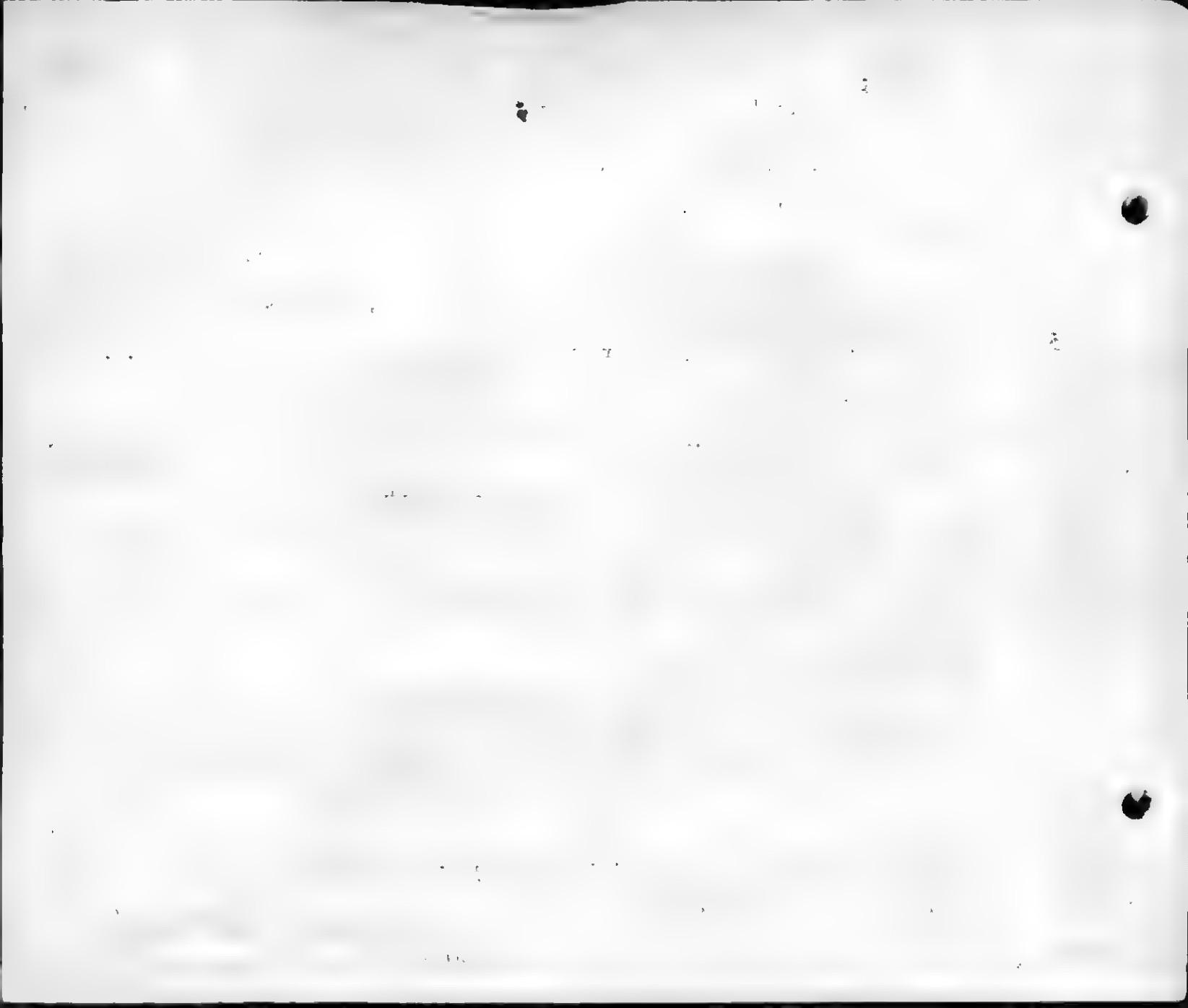
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04200

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Maryland</b>		b. COUNTY <b>Prince George's</b>	
c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Forestville, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General</b>		d. STREET ADDRESS <b>7673 Walters Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Sherman</b>	Middle <b>Ray</b>	Last <b>Horton</b>
4. DATE OF DEATH	Month <b>March</b>	Day <b>16</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 10, 1932</b>
9. AGE (in years last birthday) <b>33 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glass worker</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Deer + Window MFG</b>	12. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
13. FATHER'S NAME <b>Erman Horton</b>	14. MOTHER'S MAIDEN NAME <b>Virvia Bailey</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or dates of service) <b>Yes KOREAN</b>	
16. SOCIAL SECURITY NO. <b>232-42-8244</b>		17. INFORMANT <b>Therman Horton -Brother</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address 521 69th Place Seat Pleasant, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 4301 DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b) <b>Myocardial infarction</b> DUE TO (c) <b>Coronary arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Cornelius J. Burns, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Cornelius J. Burns, M.D., Cheverly, Md.</b>		DATE SIGNED <b>3/17/66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>20 MAR. 1966</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>BLUE RIDGE MEMORIAL GARDEN W.W. Chambers Co Riverdale, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>		24a. REC'D BY REGISTRAR <b>Charles Judge</b>	
24b. REGISTRAR'S SIGNATURE <b>MAR 23 1966</b>			



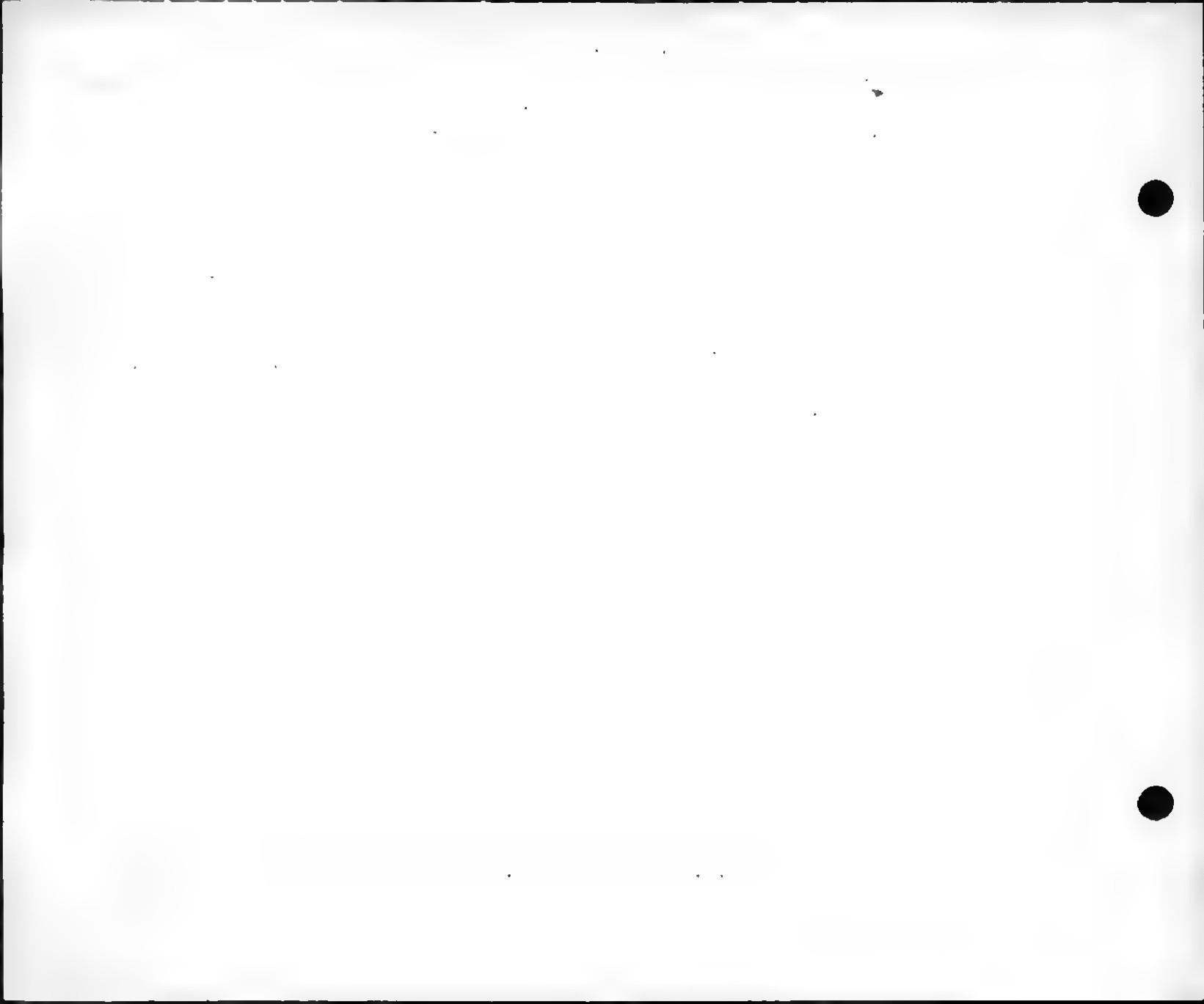
Items 18&21 Film G378 7 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Maryland b. COUNTY Prince George's									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Suitland									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 5513 Parkland Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Karen	Middle Vivian	Last Howie	4. DATE OF DEATH 3 23 19 66			Month	Day	Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED W DIVORCED		8. NEVER MARRIED		B. DATE OF BIRTH 22 March 1945		9. AGE (In years last birthday) 21 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Washington, D. C.					
13. FATHER'S NAME Joseph M. Knott						14. MOTHER'S MAIDEN NAME Vivian Ward							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.			17. INFORMANT John R. Howie 5513 Parkland Court			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cause undetermined</u> DUE TO (c)													
INTERVAL BETWEEN ONSET AND DEATH													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b)									
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, room, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 3-24-66			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3-26-66		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland		(County) Maryland		(State)			
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Rd Suitland Maryland		25a. REGD BY REGISTRAR MAR 29 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

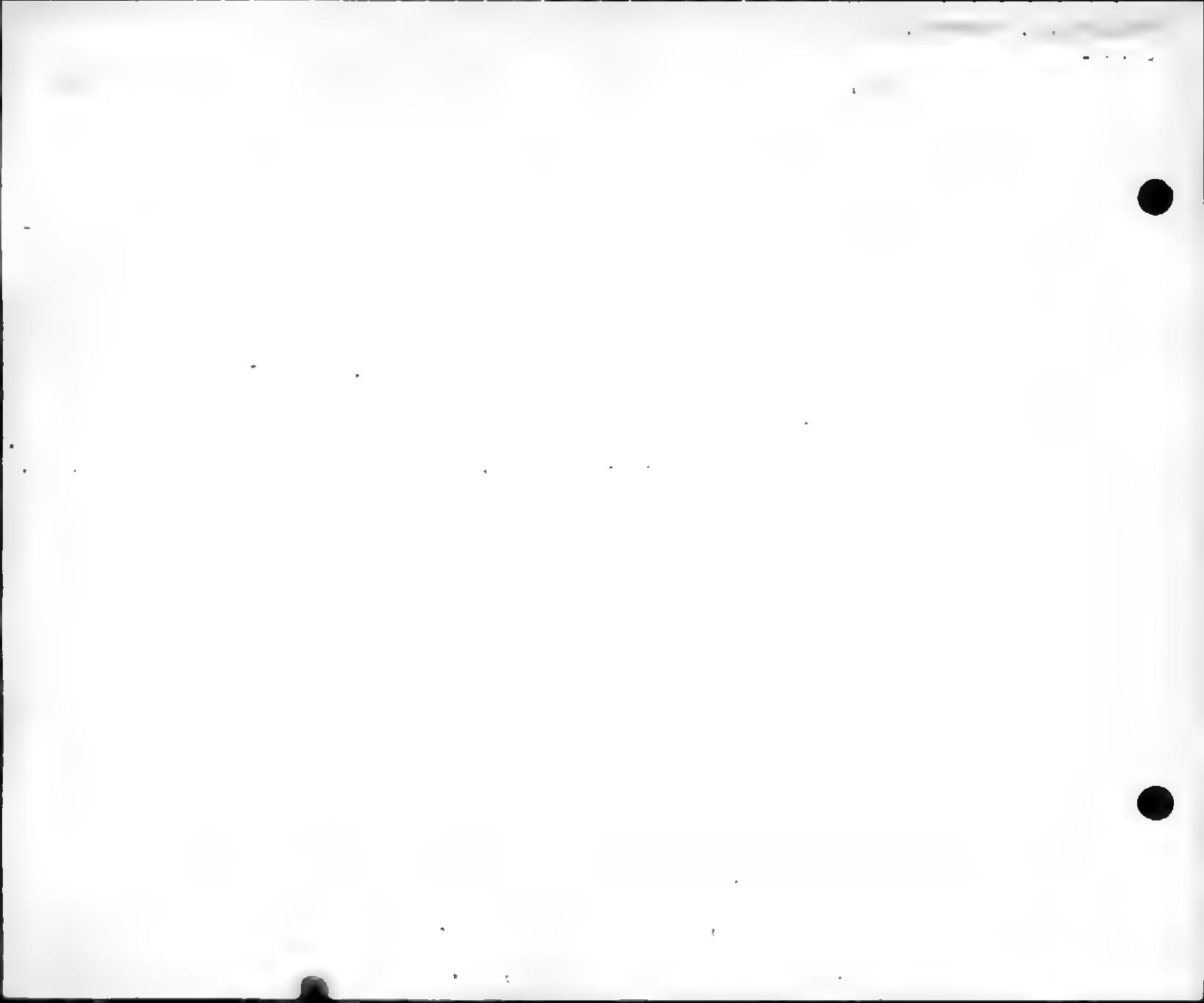
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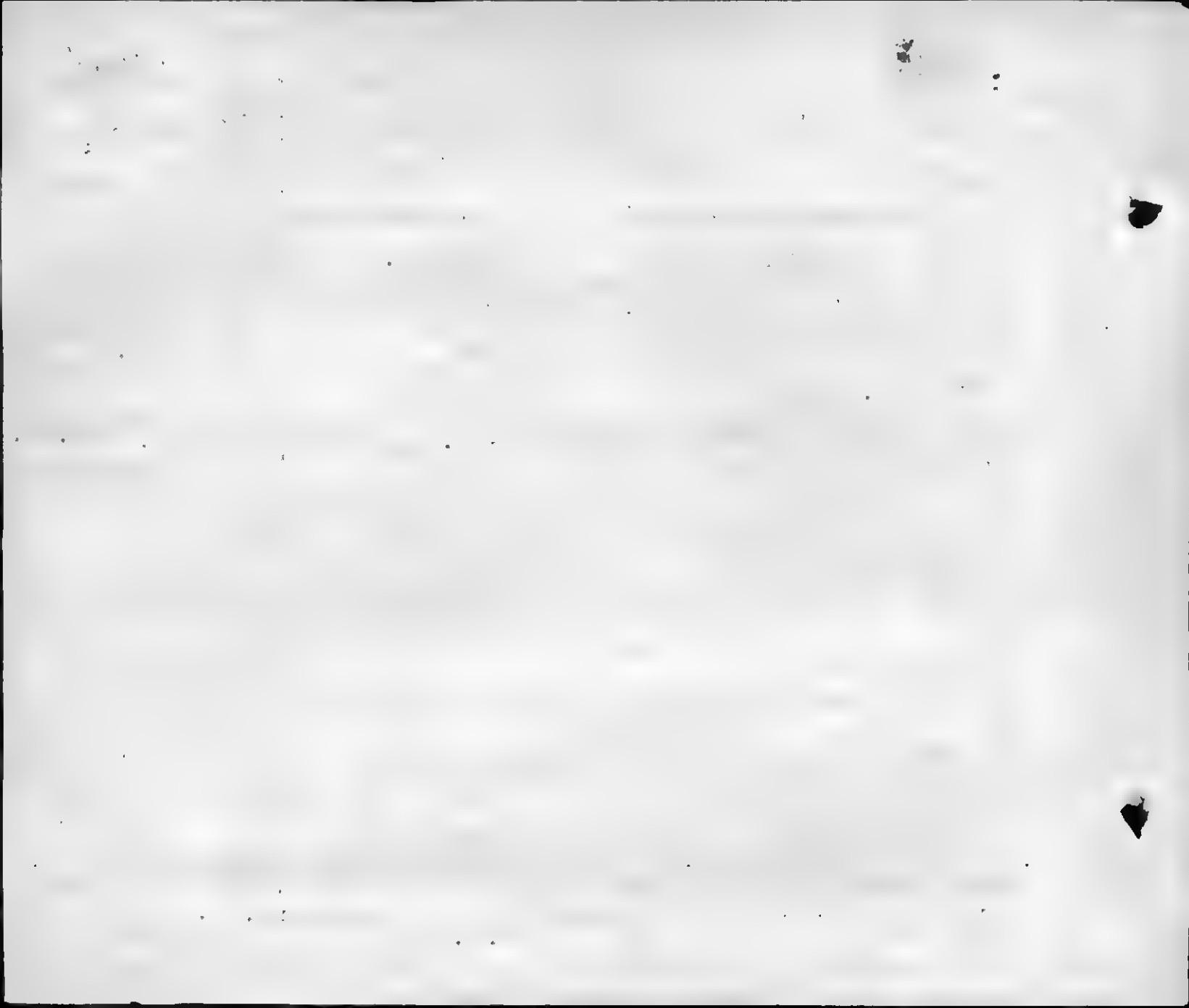
**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b. COUNTY Prince George's		
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville			c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7006 Barton Road			e STREET ADDRESS 7006 Barton Road		
3 NAME OF DECEASED (Type or print) William E. Worth Hudson			4 DATE OF DEATH Month 3 Day 7 Year 1966		
S SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED	8 DATE OF BIRTH 2-13-03	9 AGE (in years last birthday) yrs. 63	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Book Binder			11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		
13 FATHER'S NAME William E. Hudson			14 MOTHER'S MAIDEN NAME Matilda (unknown)		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO 216-10-6274		
17 INFORMANT Mrs. Helen King (daughter) Alexandria, a.			Address 7041 Barbara Rd.		
18 CAUSE OF DEATH (Enter one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 1411 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aortic Stenosis DUE TO (c) Rheumatic Valvular Heart Disease			INTERVAL BETWEEN ONSET AND DEATH Minutes over 5 years years		
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Lehoe L.D., Maryland				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF March 10, 1966	23c NAME OF CEMETERY OR CREMATORIAL Park	23d LOCATION (City or Town) Elkridge RFD, Maryland	(County) (State)
24. FUNERAL DIRECTOR Richard V. Singleton		ADDRESS Glen Burnie, Md.		25a REG'D BY REGISTRAR MAR 10 1966	25b REGISTRAR'S SIGNATURE Charles Judge







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

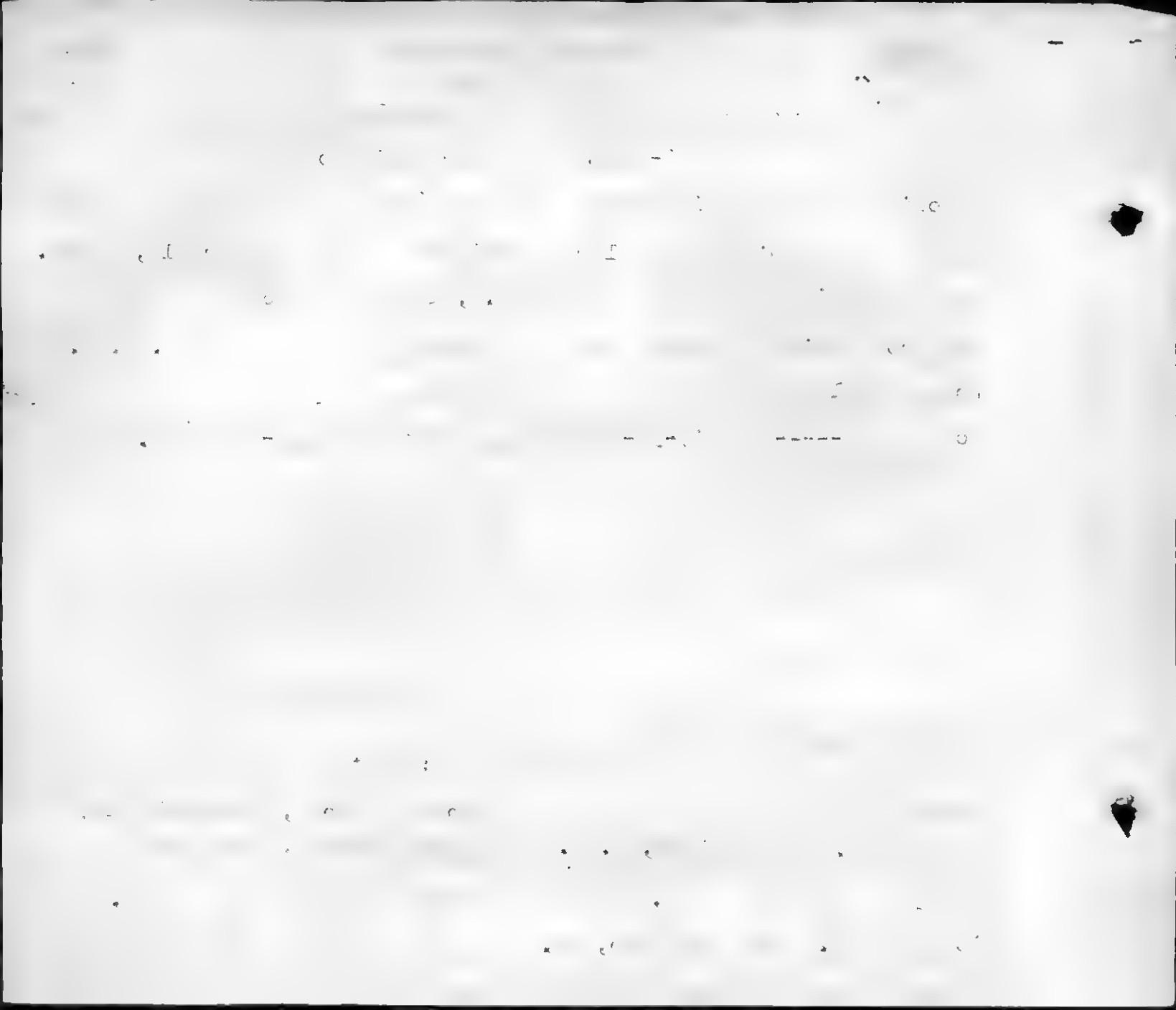
Reg. Dist. No.

04204

M		04212		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
1. PLACE OF DEATH a. COUNTY		Prince Georges MARYLAND		a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. LENGTH OF STAY IN 1b 3-Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Magnolia Gardens Nursing Home				d. STREET ADDRESS RFD Box 2266	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Ephriam	Middle Wallace	Last Ireland	4. DATE OF DEATH March 12, 1966.
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1879	9. AGE (In years lost birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		10c. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Ireland		14. MOTHER'S MAIDEN NAME Sarah		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO 217-36-9834		17. INFORMANT Julia Agnes Ireland- Same as Item #2, Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarction			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Arthritis/Arterio-Blood Vascular Disease			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Leeland	(County) (State) Md.
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9:15 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>A. Clark Holmes, M. D.</i>		DATE SIGNED 3/12/66			
PHYSICIAN'S NAME (Type)		M.D. Upper Marlboro, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/66	22c. NAME OF CEMETERY OR CREMATORIUM St. Barnabas Cemetery	22d. LOCATION (City, town, or county) Leeland	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		ADDRESS Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR MAR 23 1966	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

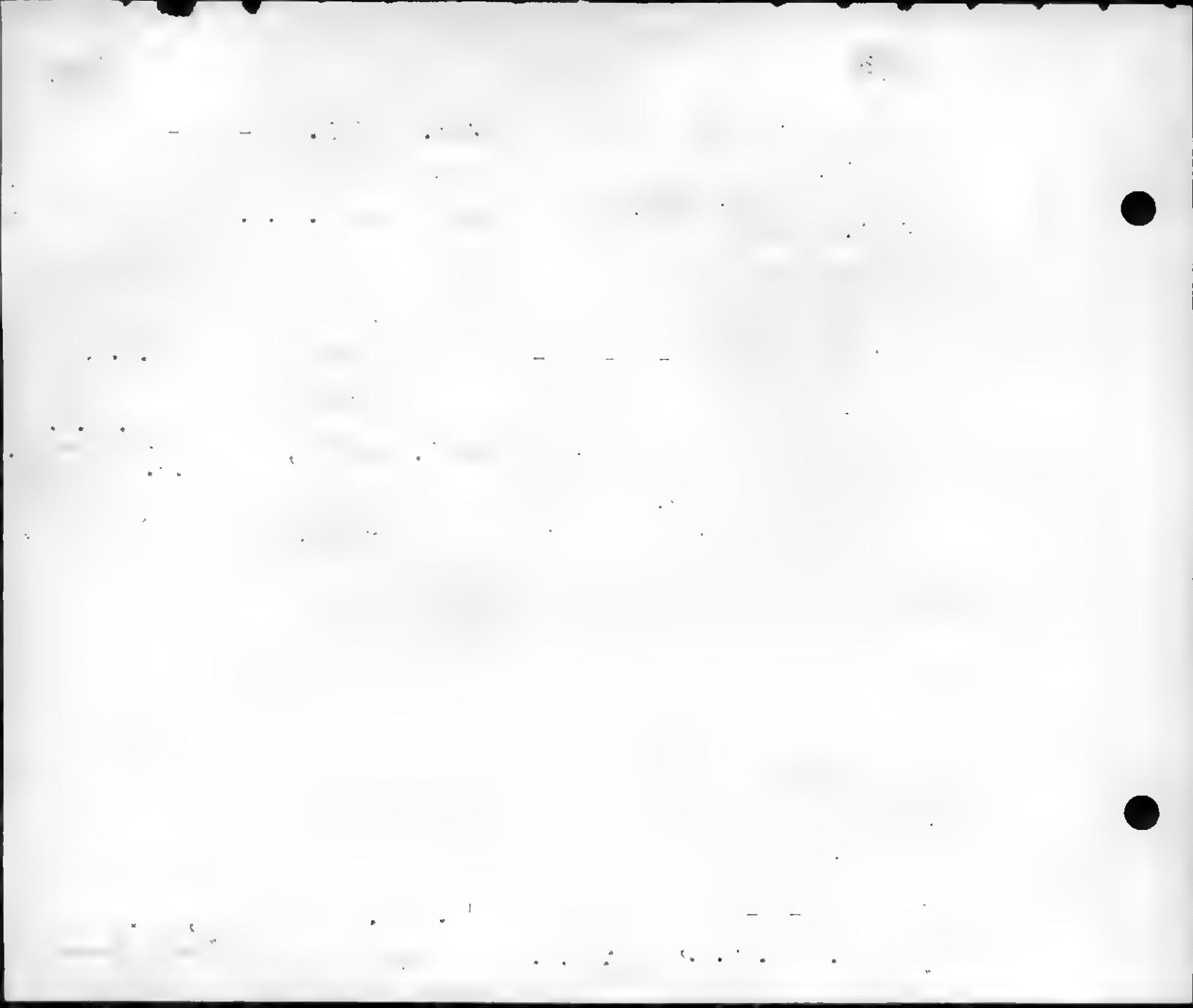
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <b>Prince Georges</b>				a. STATE <b>Distr. of Col.</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				b. COUNTY									
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Hyattsville Nursing Home</b>				d. STREET ADDRESS <b>4516 5th St. N.W.</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
<b>ETHEL</b>		<b>L - JACKSON</b>		<b>MARCH 23,</b>	<b>1966</b>								
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?						
<b>F</b>	<b>White</b>	<b>WIDOWED <input checked="" type="checkbox"/></b>	<b>1 - 7 - 84</b>	<b>82 yrs.</b>	<b>-</b>	<b>North Carolina</b>	<b>U.S.A.</b>						
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME												
<b>DANIEL A. McCrary</b>	<b>Lou MORRIS</b>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <b>Wash. D.C.</b>										
	<b>579-60-8724</b>	<b>Hayes T. Jackson, 4702 Brandywine St. N.W.</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
Cardiac arrest													
DUE TO													
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)													
Arteriosclerotic heart disease													
DUE TO													
(c)													
INTERVAL BETWEEN ONSET AND DEATH minutes													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
Chronic severe malnutrition													
20a. MEDICAL CERTIFICATION	20b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20c. TIME OF INJURY	Month, Day, Year	Hour a.m. p.m.	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	21. I certify that (I) (this hospital) attended the deceased from <b>Dec 10, 1965</b> , to <b>March 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 21, 1966</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
					While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>								
22a. SIGNATURE	<b>Hansel W. Draper</b>											22b. DATE SIGNED <b>March 23, 1966</b>	
22c. PHYSICIAN'S NAME (Type)	<b>HANSOLD W. DRAPER M.D.</b>											22d. ADDRESS <b>911 Silver Spring Ave, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county) (State)										
<b>Burial</b>	<b>3-25-1966</b>	<b>Arlington Nat'l. Cem.</b>	<b>Arlington, Va.</b>										
24. FUNERAL DIRECTOR	ADDRESS	25a. HELD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE										
<b>Joseph Gowler's Sons, Inc.</b>	<b>5130 Wisconsin Ave. N.W., Wash. D.C.</b>	<b>DATE</b>	<b>MAR 28 1966</b>										
			<b>Charles Judge</b>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

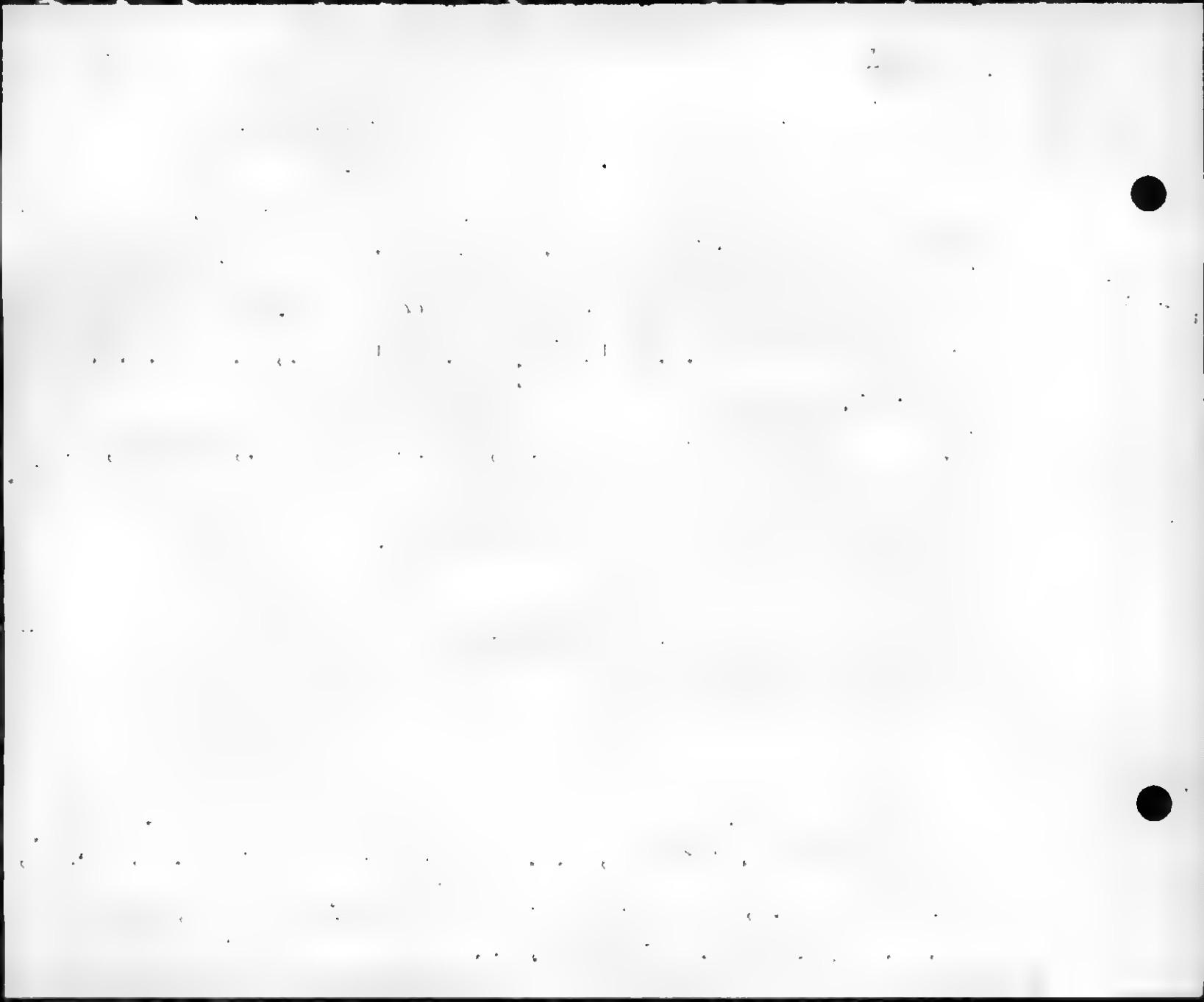
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

U4206

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Lawrence unknown</i>		c. LENGTH OF STAY IN 1b <i>unknown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Magnolia Gardens Nursing Home</i>		e. STREET ADDRESS <i>9515 Defense Highway</i>	
3. NAME OF DECEASED (Type or print) <i>First THOMAS Middle H. JAMESON SR.</i>		4. DATE OF DEATH <i>January 4 1966</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/4/76</i>	
9. IF UNDER 1 YEAR Months <i>89</i> yrs. Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		10. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clark</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't off. Land Dept.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>St. Mary's Cty., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS I. JAMESON</i>		14. MOTHER'S MAIDEN NAME <i>SARA ANN LOVE</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Thomas H. Jameson Sr., Highway, Seabrook</i>		Address <i>9515 Defense</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>day 6 mo</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac thrombosis</i>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>Generalized arteriosclerosis</i>			
DUE TO (b) <i>hypertension chronic</i>			
DUE TO (c) <i>generalized arteriosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>hypertension chronic</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>White at work</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 1965 to 1966, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, M, from the causes and on the date stated above.		22b. DATE SIGNED <i>Mar. 4, 1966</i>	
22a. SIGNATURE <i>Leon R. Levitsky, M.D.</i>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Mar. 4, 1966 Md.	
22c. PHYSICIAN'S NAME (Type) <i>Leon R. Levitsky, M.D.</i>		22d. ADDRESS <i>3408 Rhode Island Ave. Mt. Rainier,</i>	
23a. BURIAL CEREMONY <input type="checkbox"/> X (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar. 7, 1966</i>	
23c. NAME OF CEMETERY OR GRAVE MARKER <i>Fort Lincoln Cemetery Bladensburg, Maryland</i>		23d. LOCATION (City, town or county) (State) <i>Bladensburg, Maryland</i>	
24. FUNERAL DIRECTOR <i>W. W. CHAMBERS CO., Riverdale, Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 7 1966</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

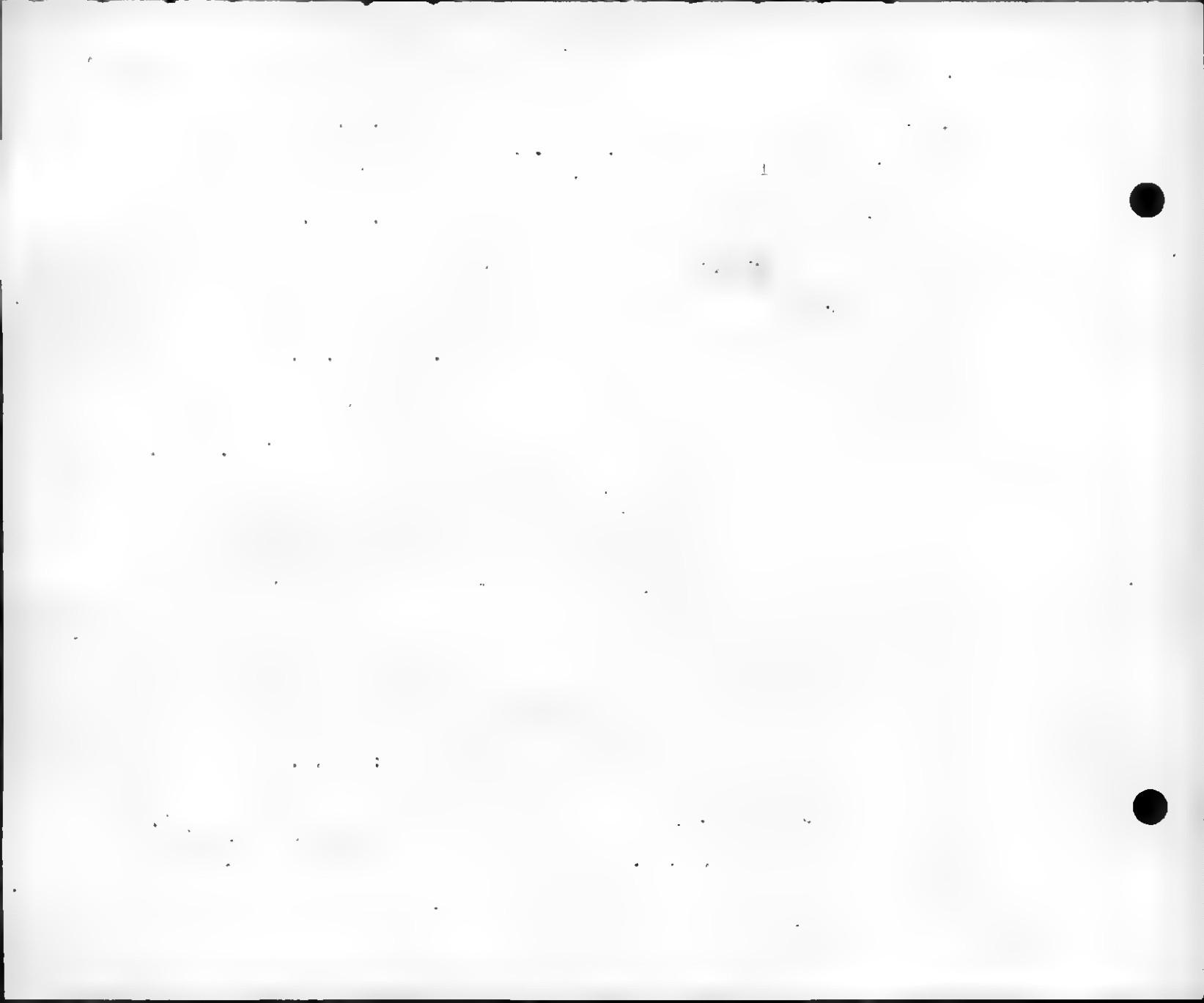
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

04215 04207

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> 15 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>130 S St. N. W.</b>	
3. NAME OF DECEASED (Type or print)	First <b>Lillian</b>	Middle <b>Johnson</b>	Last Month Day Year <b>March 4 19 66</b>
4. SEX <b>Female</b>	5. COLOR OR RACE <b>Negro</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>3/17/1910</b>
8. AGE (in years last birthday) <b>55 yrs.</b>	9. IF UNDER 1 YEAR Months Days Hours Min. <b>IF UNDER 24 HRS.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Roland</b>		14. MOTHER'S MAIDEN NAME <b>Mary Clayton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Esther Lancaster, 130 S St. N. W.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia and pulmonary abscesses</b> 4 DUE TO <b>Septicemia due to severe pyogenic infection of</b> (b) <b>the urinary bladder (organism undetermined)</b> DUE TO <b>Hypertensive and arteriosclerotic cardiovascular</b> (c) <b>disease with recurrent cerebrovascular accidents</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While Not While p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED factory, street, office bldg., etc.)	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>8/17 1964</b> to <b>3/4 1966</b> , that (2) (we) last saw the deceased alive on <b>3/4 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED <b>3/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Glenn Dale Hospital</b> <b>Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> <b>3/10/66</b>		23b. DATE THEREOF <b>Lincoln Memorial Ceme.</b> Maryland	
23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Stewart Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 8 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>John Stewart</i> <i>John Stewart</i> <i>John Stewart</i> <i>John Stewart</i> <i>John Stewart</i> <i>John Stewart</i> <i>John Stewart</i> <i>John Stewart</i>	



Item 18 Film 377 6-10 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04216

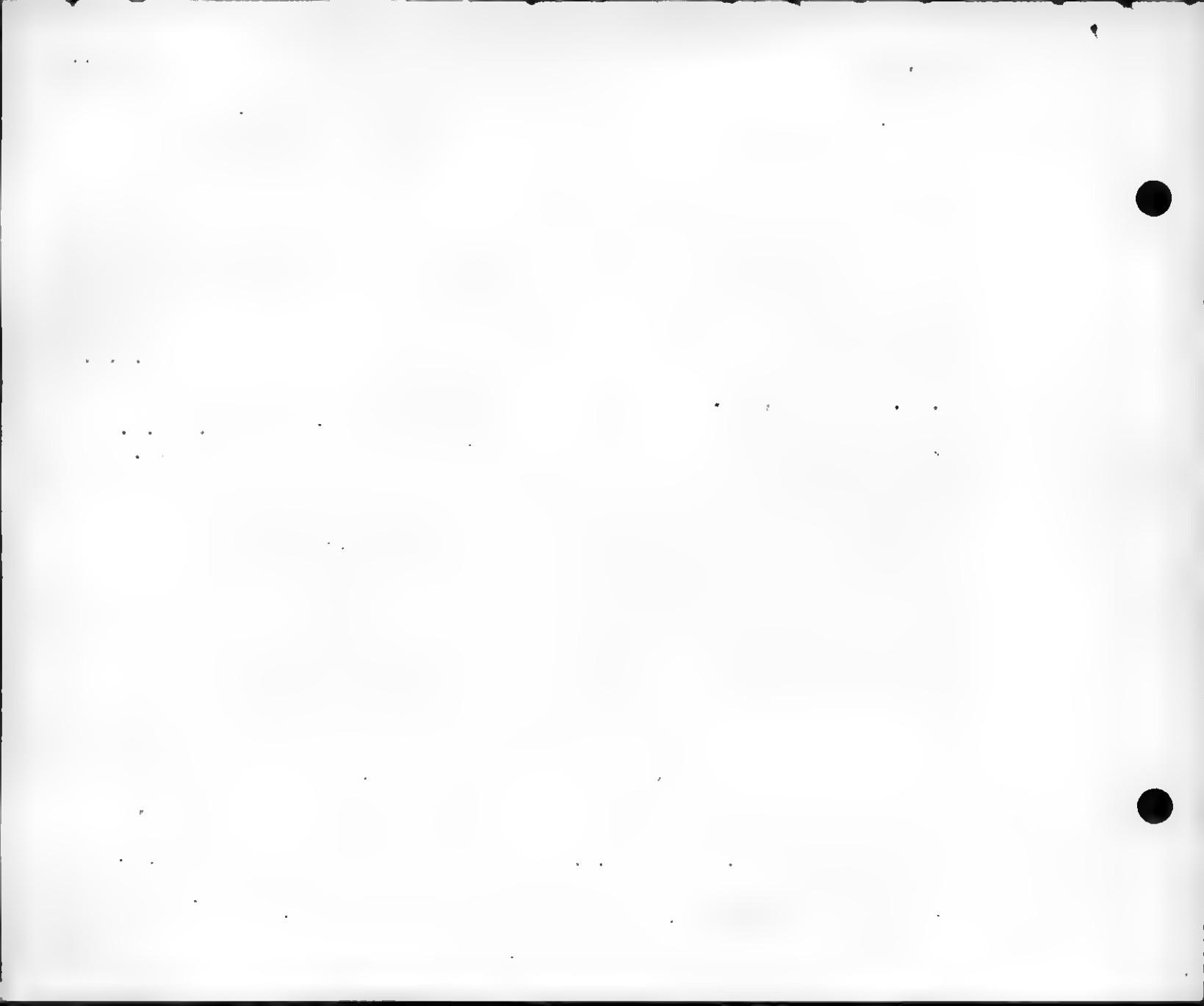
## CERTIFICATE OF DEATH

04208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Loretta</b>	Middle <b>Johnson</b>	4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-15-15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		9. AGE (in years last birthday) <b>51 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Wm. J. Stockett, Sr.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Nathaniel Ford</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>Congestive Heart Failure</b> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>4200</b> DUE TO <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Washington, D.C.</b>		(County) (State)	
21. I certify that <b>(this hospital)</b> attended the deceased from <b>March 6, 1966</b> , to <b>March 11, 1966</b> , that <b>(we)</b> last saw the deceased alive on <b>March 11, 1966</b> , and that death occurred at <b>1:55 P.M.</b> from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>3/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince George's General Hosp. Cheverly Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/15/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Mutual Cemetery</b>
24. FUNERAL DIRECTOR <b>Ron McMurtry</b>		23d. LOCATION (CITY, TOWN OR COUNTY) (STATE) <b>Sandy Spring, Maryland</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
		25b. REGISTRAR'S SIGNATURE	



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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

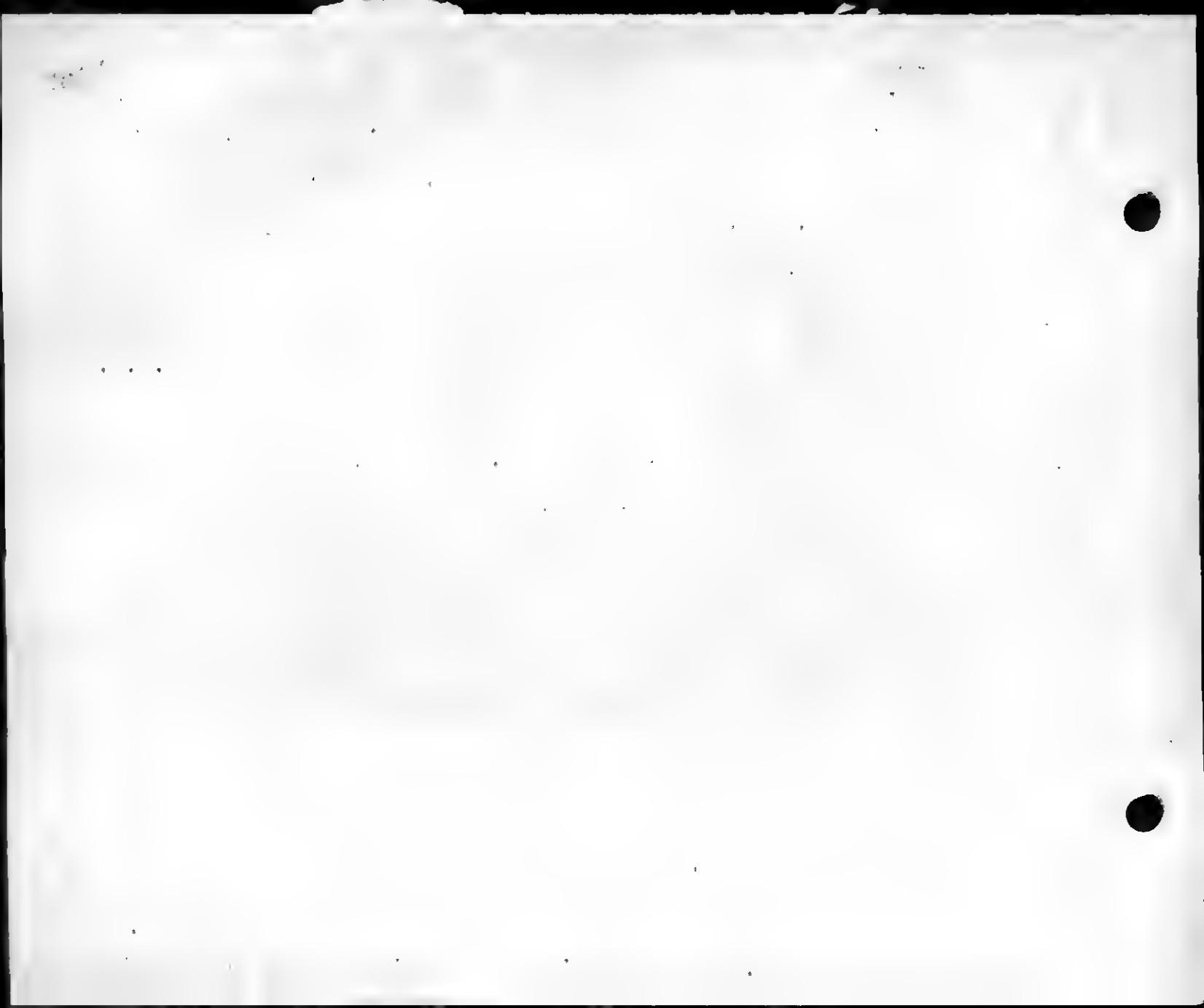
## CERTIFICATE OF DEATH

042009

2217

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be excused within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

1. PLACE OF DEATH ■ COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>18 HRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Geo. Gen. Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Dorothy</b>	Middle <b>Ester</b>	Last <b>Kells</b>
4. DATE OF DEATH <b>March 15 1966</b>	Month <b>March</b>	Day <b>15</b>	Year <b>1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/1893</b>
9. AGE (in years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>72 yrs.</b>	11. IF UNDER 24 HRS. Hours <b>72 hrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Sherman</b>		14. MOTHER'S MAIDEN NAME <b>Emma Benham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-1760</b>	
17. INFORMANT <b>Mr. Robert H. Kells (above address)</b>		Address <b>(Husband)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>Cerebro Vascular Accident</i>		INTERVAL BETWEEN ONSET AND DEATH <b>18 HRS</b>	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.  <i>Atherosclerotic Vascular disease</i>		5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>
20f. (City or town) <b>-</b>		(County) (State) <b>-</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>March 14, 1966</b> , to <b>March 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 14, 1966</b> , and that death occurred at <b>1 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Benjamin S. Miller</i>		22b. DATE SIGNED <b>March 15 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Benjamin S. Miller</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/19/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Evergreen Cemetery</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Maryland</b>	25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1  
FOR STATE  
HEALTH DEPT.

04213

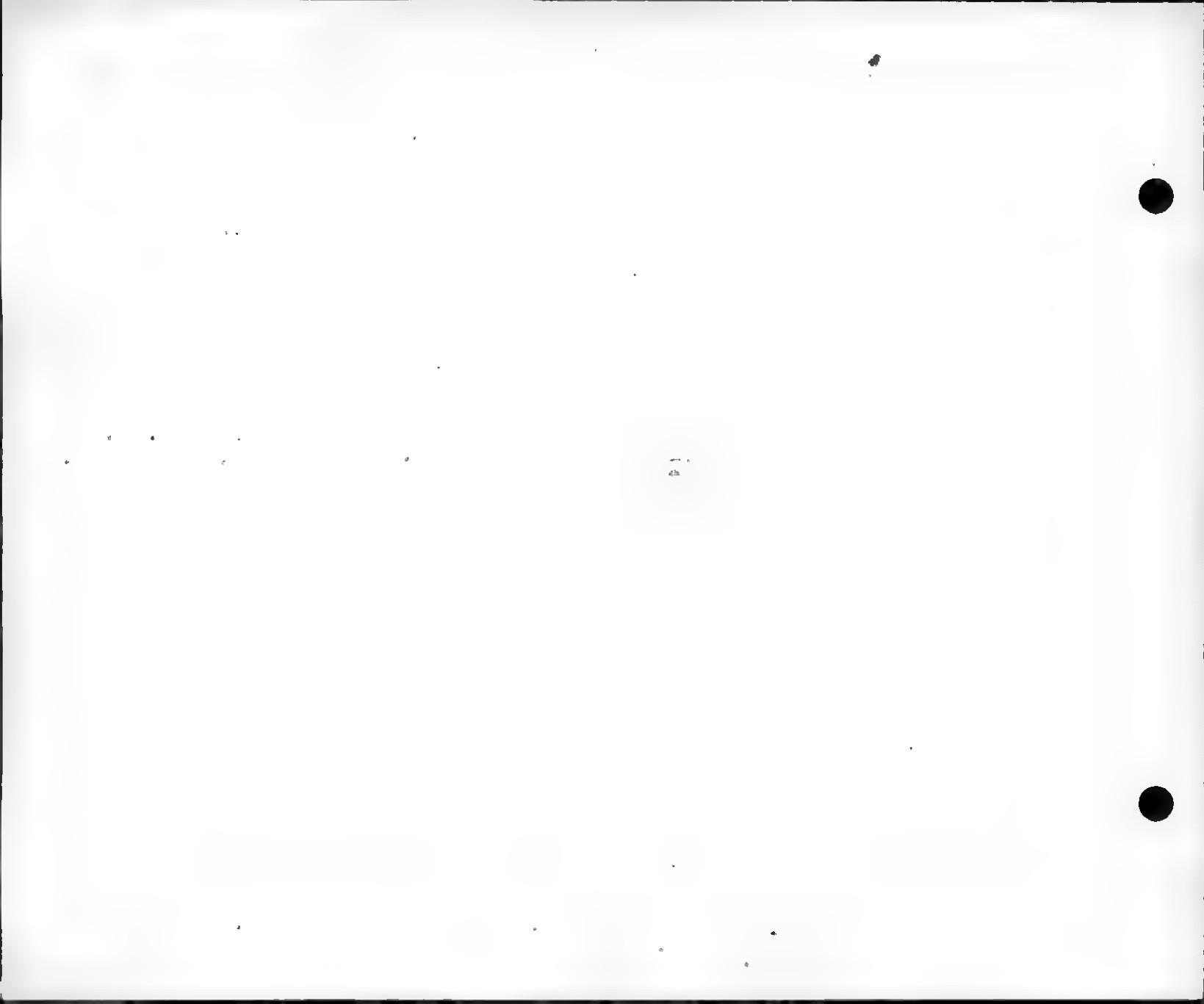
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04210

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

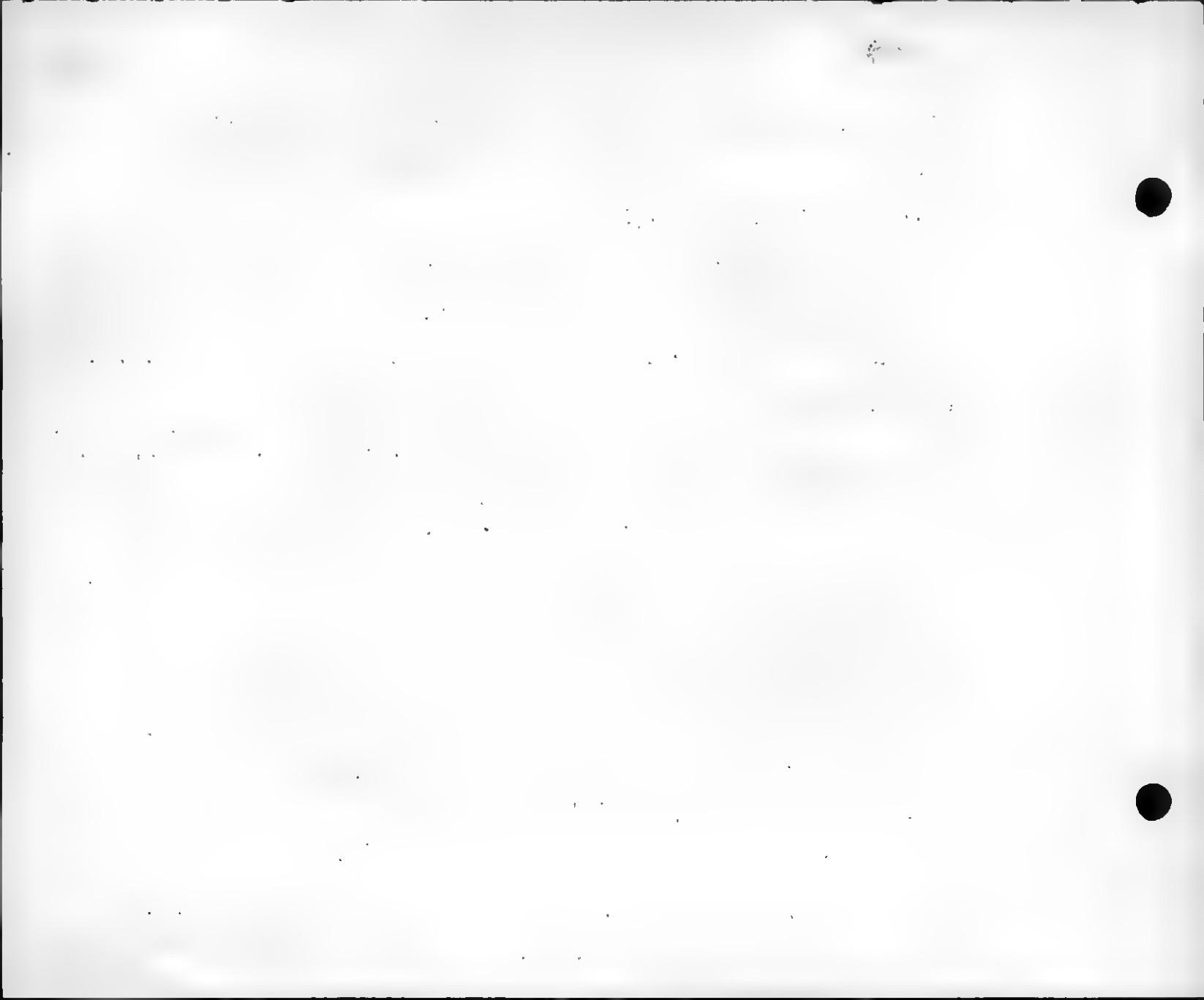
1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>34 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
3. NAME OF DECEASED (Type or print) <b>Goldie Kehoe</b>		First <b>May</b>	Middle <b>Kinsinger</b>
S SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		8 DATE OF BIRTH <b>10 June 1985</b>	
10b KIND OF BUSINESS OR INDUSTRY		9 AGE (In years at birthday) <b>80 yrs</b>	10 INFORMANT <b>Louise P. Farrell</b>
13. FATHER'S NAME <b>John Moss</b>		11 BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>	12 CITIZEN OF WHAT COUNTRY? <b>Mt. Rainier Md.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOC A. SECURITY NO <b>213-16-2329</b>	17 INFORMANT <b>4304 88th Pl.</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <b>Interstitial pneumonitis bilateral</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) (c)		DUE TO (b) DUE TO (c)	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of neck of left femur</b>			
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B) <b>Got out of bed and fell in bedroom</b>	
20c TIME OF INJURY Month, Day, Year Hour am <b>11:00 pm 2 6 1966</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f (City or town) <b>Same as #2</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>3-13-66</b>	
23a BURIAL/CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Mar. 15/66</b>	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arl. Natl. Cemetery</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		23d LOCATION (City or Town) <b>Virginia</b>	23e RECEIVED BY REGISTRAR <b>MAR 17 1966</b>
		23f REGISTRAR'S SIGNATURE <b>Charles Judge</b>	23g REGISTRAR'S SIGNATURE



**M** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
Prince George's MARYLAND				a. STATE b. COUNTY							
D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Cheverly 17 days				Landover							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS							
Prince George's General Hospital				2818 74th Avenue							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
			Madeline	G	Kirker	March	8	1966			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8/8/91		74 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife			Own Home			Rhode Island			U.S.A.		
13. FATHER'S NAME											
James S. Drury Margaret Regan											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
no								Clarence A. Kirker Jr. Hyatts, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Surgical shock</u> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH if hrs</span>											
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding Peptic ulcer</u> 3 weeks (c) <u>Peptic (Stomach) ulcer</u> years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
19									20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 27</u> , 19 <u>66</u> to <u>Mar 7</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive <u>Mar 7</u> , 19 <u>66</u> , and that death occurred at <u>10:25</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dayton O. Watkins</u>											
22c. PHYSICIAN'S NAME (Type) <u>DAYTON O. WATKINS</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town or county) (State)		
Burial			3/11/66			Mt. Olivet			Washington D.C.		
24. FUNERAL DIRECTOR											
Francis Gasch's Sons Hyattsville, Md.											
25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
DATE MAR 10 1966			Charles Judge								



FOR STATE  
HEALTH DEPT.

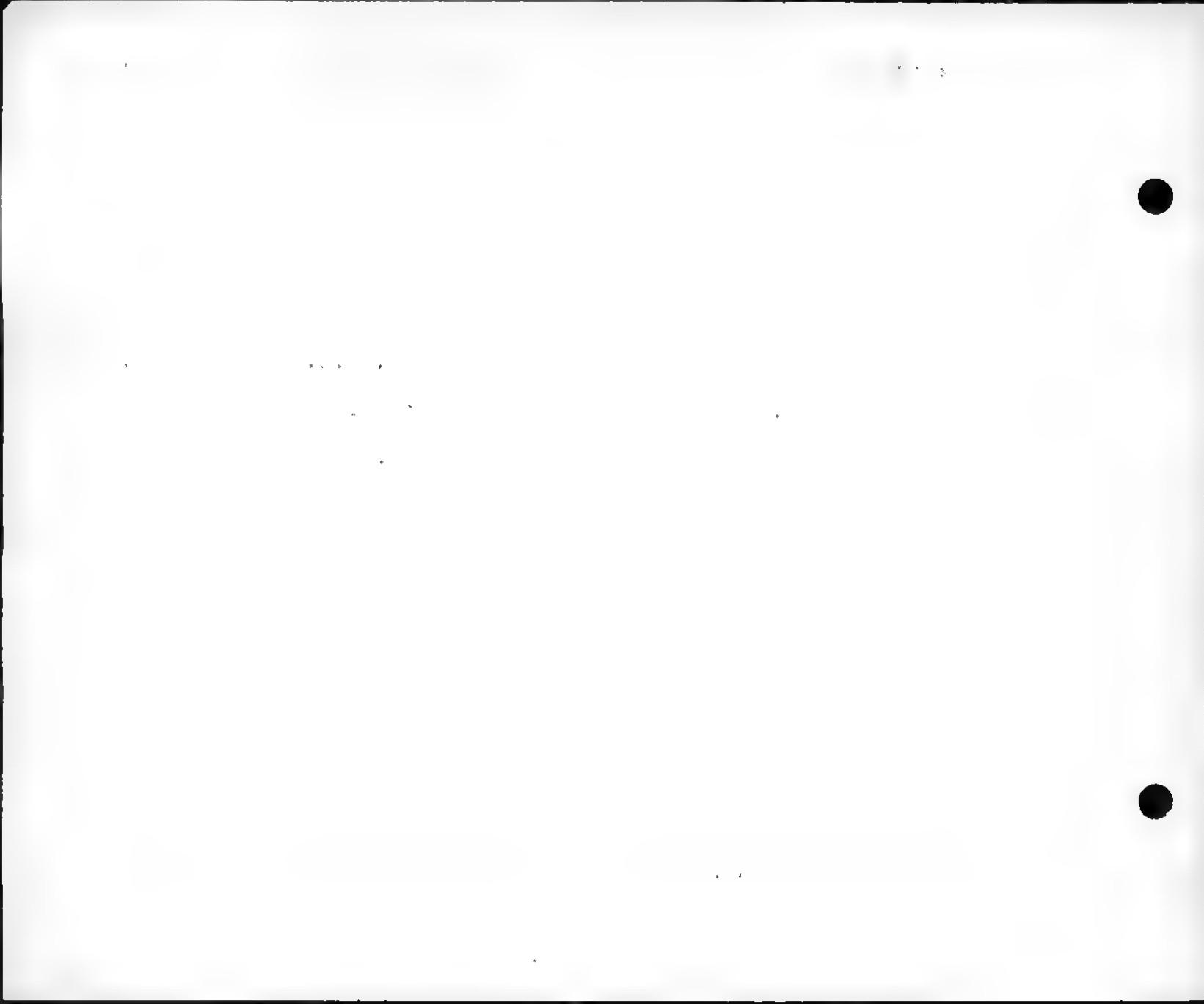
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04220				04212			
1 PLACE OF DEATH a COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		b COUNTY Prince George's					
c LENGTH OF STAY IN lb DON		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdale					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d STREET ADDRESS 7601 23rd Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) William Armond Knott		First	Middle	last	4 DATE OF DEATH 3 13 1966		
5 SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-8-16	9 AGE (in years 9 yrs old birthday) 49 yrs	10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Wash., D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME James S. Knott		14 MOTHER'S MAIDEN NAME Jane M. Guy		Address Same as			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 573 05 6992		17 INFORMANT Margaret V. Knott		18 INTERVAL BETWEEN ONSET AND DEATH minutes	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) f 200 Heart Failure		DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Arteriosclerotic Heart Disease				over 3 years	
DUE TO		(c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)					
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kohoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 3-13-66	
EXAMINER'S NAME (Type) John Kohoe M.D., Riverdale, Maryland Address (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 3-16-1966		23c NAME OF CEMETERY OR CREMATORIUM Nat'l Memorial Park		23d LOCAT ON (City or Town) (County) (State) Falls Church, Va	
24 FUNERAL DIRECTOR <i>Gilbert A. Mattingly</i>		ADDRESS 131 11th St S.E. Wash DC		25a REC'D BY REGISTRAR MAR 15 1956		25b REGISTRAR'S SIGNATURE <i>Waverly Judge</i>	



**TO HOSPITAL** \_\_\_\_\_ be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04221

04213

1. PLACE OF DEATH  
a. COUNTY

Prince Georges MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Suitland

c. LENGTH OF STAY IN lb

6 years 1 Mo.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suitland Nursing Home, Inc.

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

Maud

Barnard

KNOWLES

4. DATE  
OF  
DEATH

Month March  
Day 25,

1966

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

WIDOWED  DIVORCED

Aug. 31, 1881

9. AGE (in years  
last birthday)

84 yrs.

IF UNDER 1 YEAR  
Months Days

IF UNDER 24 HRS.  
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?

Housewife & Sales Clerk Home & Department Store Washington, D. C.

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

William Neumann

Lucy Reigle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Mr. Paul E. Knowles

Address 1020 N. Quincy St.

Arlington, Virginia

INTERVAL BETWEEN  
ONSET AND DEATH

10 yrs +

10 yrs +

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a).

Hypertensive Heart Disease

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Hypertension

DUE TO

Arteriosclerosis

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a.

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m. 20d. INJURY OCCURRED  
p.m. 19 While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 16, 1966, to Mar 25, 1966, that (I) (we) last saw the deceased alive on 3/21, 1966, and that death occurred at 3:30 AM, from the causes and on the date stated above.

22. SIGNATURE  
*James C. Cawood*

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

DATE  
SIGNED  
March 25, 1966

22d. ADDRESS

2520 Pa. Ave. S.E. Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial 3/28/66

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

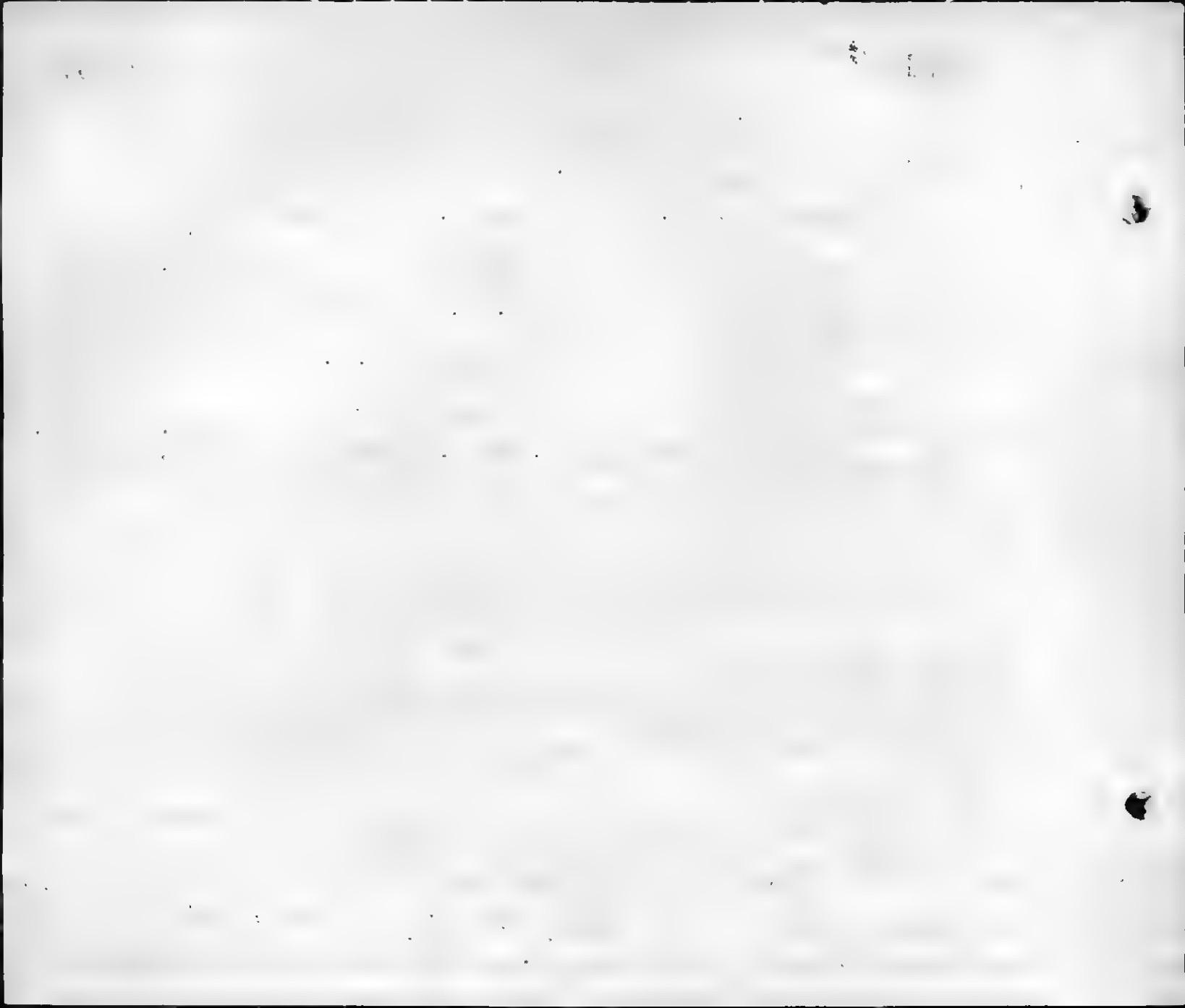
24. FUNERAL DIRECTOR'S SIGNATURE  
*James C. Cawood*

ADDRESS 3901 N. Fairfax

REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Arlington, Va.

MAR 28 1966 *Charles Judge*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

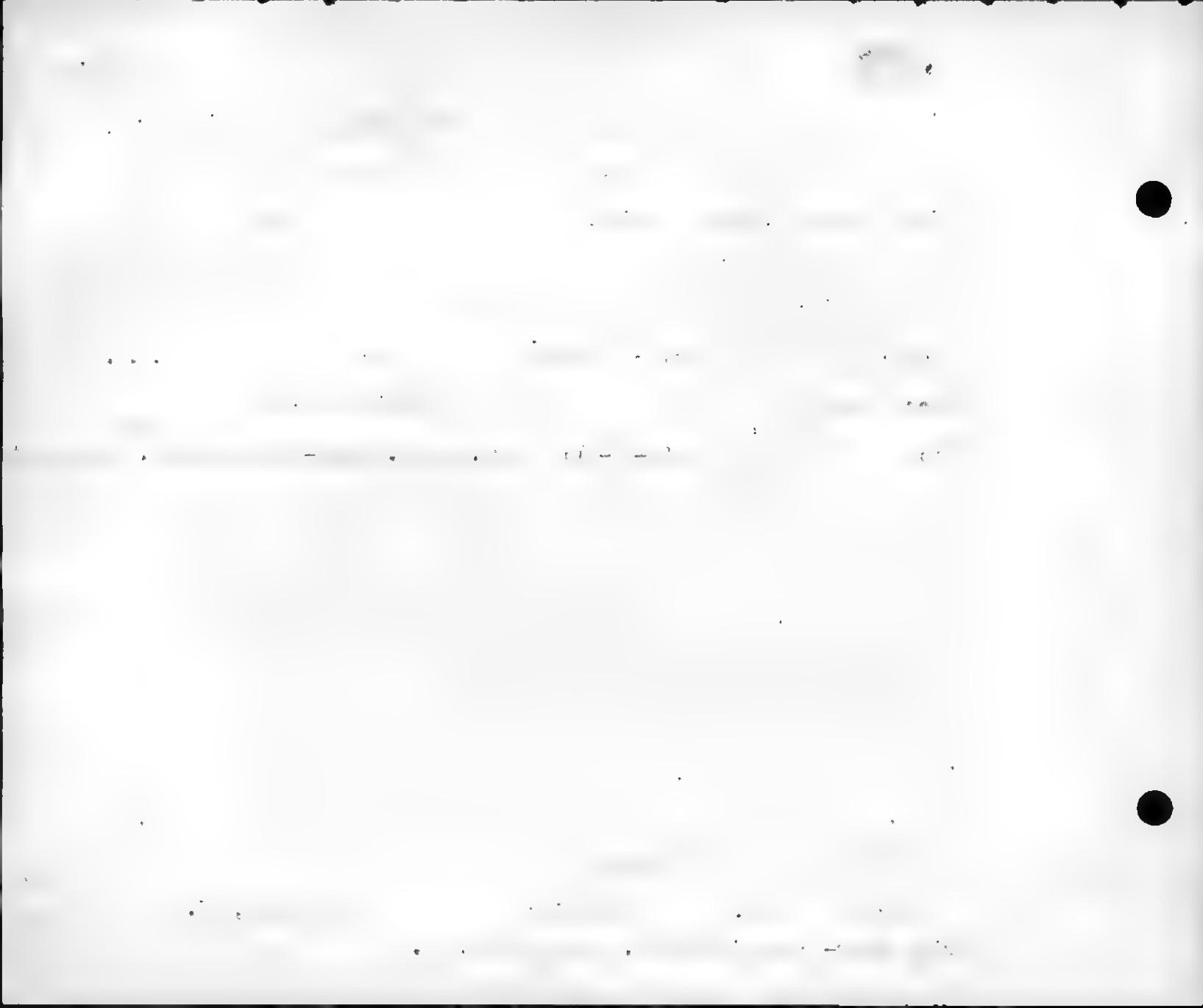
1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04222  
04214

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		Marlow Heights	
3. NAME OF DECEASED (Type or print) <b>Harry</b>		First <b>B</b>	Middle <b>Krebs</b>
4. DATE OF DEATH <b>March 10 1966</b>	Month <b>March</b>	Day <b>10</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-24-77</b>
9. AGE (in years last birthday) <b>88 yrs.</b>	10. FUNERAL 1 YEAR Months <b>88</b>	11. FUNERAL 24 HRS. Days <b>88</b>	12. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Baker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Krebs</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Boekel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-10-9169</b>	
17. INFORMANT <b>Mrs. Ida K. Krebs</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of lungs</b> 197X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of prostate</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchopneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 28, 1966</b> , to <b>March 10 1966</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 10 1966</b> , and that death occurred at <b>2:35 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Edwin J. Jensen</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen</b>		22d. ADDRESS <b>22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>	22b. DATE SIGNED <b>March 10, 1966</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/14/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Druid Ridge</b>
24. FUNERAL DIRECTOR <b>Loring Byers - 8728 Liberty Rd. Randallstown, Md.</b>		25a. ADDRESS <b>DATE</b>	25b. REC'D. BY REGISTRAR <b>MAR 14 1956</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**TO HOSPITAL** \_\_\_\_\_ be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be filled with the attending physician.

VR A15 (4)  
ISM 7-62

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04223

04215

1. PLACE OF DEATH

a. COUNTY

PRINCE GEORGE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

3 YRS.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

CARROLL MANOR 4922 Dr. Bell Rd.  
First Middle

3. NAME OF

ANDREW F. LEEDY

4. SEX

M

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

D.C.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

N.W. WASHINGTON

d. STREET ADDRESS

1190 GEORGIA AVE.

e. IS RESIDENCE ON A FARM?

YES  NO

5. SEX

Last Month Day Year

4. DATE OF DEATH MARCH 18 1966

B. DATE OF BIRTH

Feb. 21-1871

9. AGE (In years last birthday)

95 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY II. BIRTHPLACE (County & State, or foreign country)

ARCHITECT

MAMARONECK, NEW YORK U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Leedy

14. MOTHER'S MAIDEN NAME

DOLAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

SR. AGNES CARROLL MANOR 4922 Dr. Bell Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.

DUE TO

(c)

Arteriosclerotic Heart Disease 3 yrs.

Generalized Arteriosclerosis 15 yrs.

heights. not

INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?

YES  NO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

None

19. WAS AUTOPSY PERFORMED?

20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year

Hour e.m.

19

p.m.

WHILE

NOT WHILE

at work

at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 15, 1966 to Mar. 18, 1966 that (I) (we) last saw the deceased alive on Mar. 18, 1966 and that death occurred at 8PM, from the causes and on the date stated above.

22a. SIGNATURE

FRANCIS P. HANNAN, M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF

22b. DATE SIGNED

PHYSICIAN'S NAME (Type)

FRANCIS P. HANNAN, MD. 1511-17 ST. N.W. WASHINGTON, DC

23a. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

Burial

3-21-66

23c. NAME OF CEMETERY OR CREMATORIAL

H. Mary's Cemetery

23d. LOCATION (City, town or county)

Ave

(State)

7/3

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Beth Funeral Home

791-11th & C. D.C.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAR 22 1966 Charles Judge

DATE



1  
MFOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04216

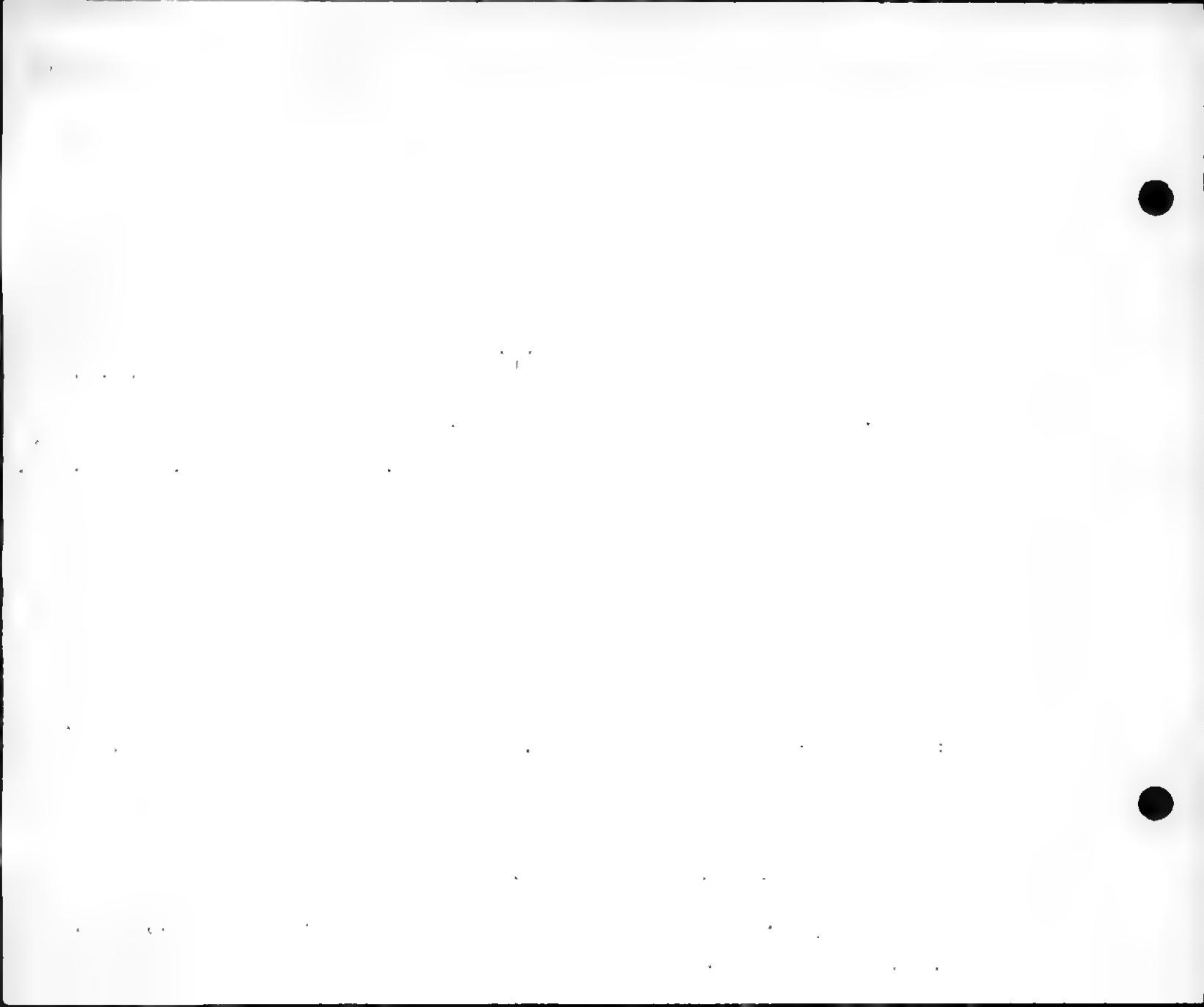
04224

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

99

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Neville</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN Tb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol, q.v. street address) <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>12614 Kinder Place</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNETTE LOUISE LEININGER</b>		4. DATE OF DEATH Month <b>3</b>	Day Year <b>31 1966</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>2-27-1935</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home-Gov't</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
13. FATHER'S NAME <b>Frank A. Thas</b>		14. MOTHER'S MAIDEN NAME <b>Eane Eshleman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Theodore C. Leininger, Pl., Bowie, Md.</b>
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>164</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) <b>multiple skull fractures</b>	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver of car involved in head-on collision.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:40 a.m. 3-31- 1966</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 450, 127 ft. east of Race Track Rd., Bowie,</b>
		20f. (City or town) <b>Md.</b>	(County) <b>(State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Konos</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Konos, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county) <b>3-31-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 4, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Creswell Cemetery</b>
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO.</b>		ADDRESS <b>Riverdale, Md</b>	25a. RECEIVED BY REGISTRAR DATE <b>APR 4 1966</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

M

04225

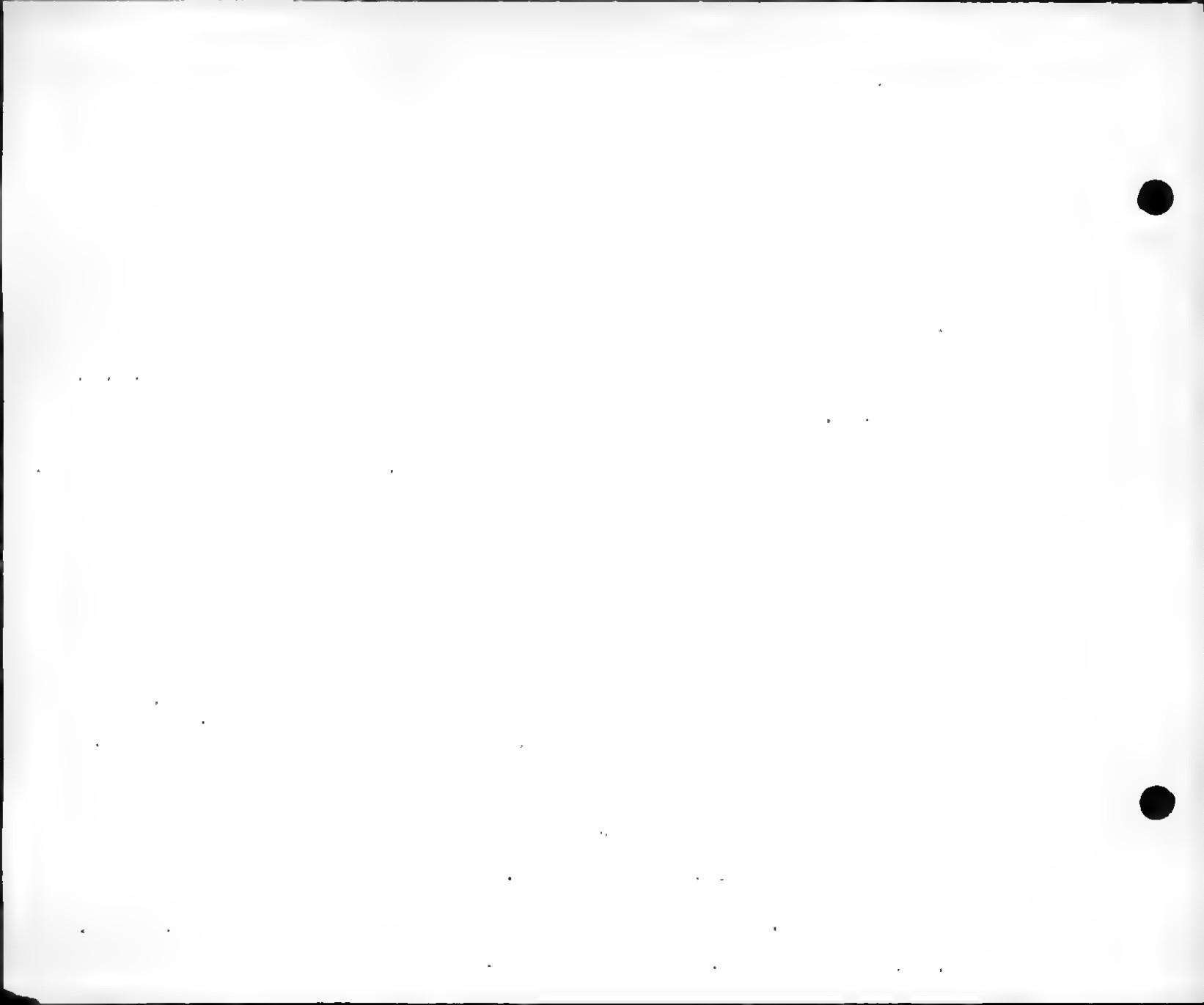
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04217

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

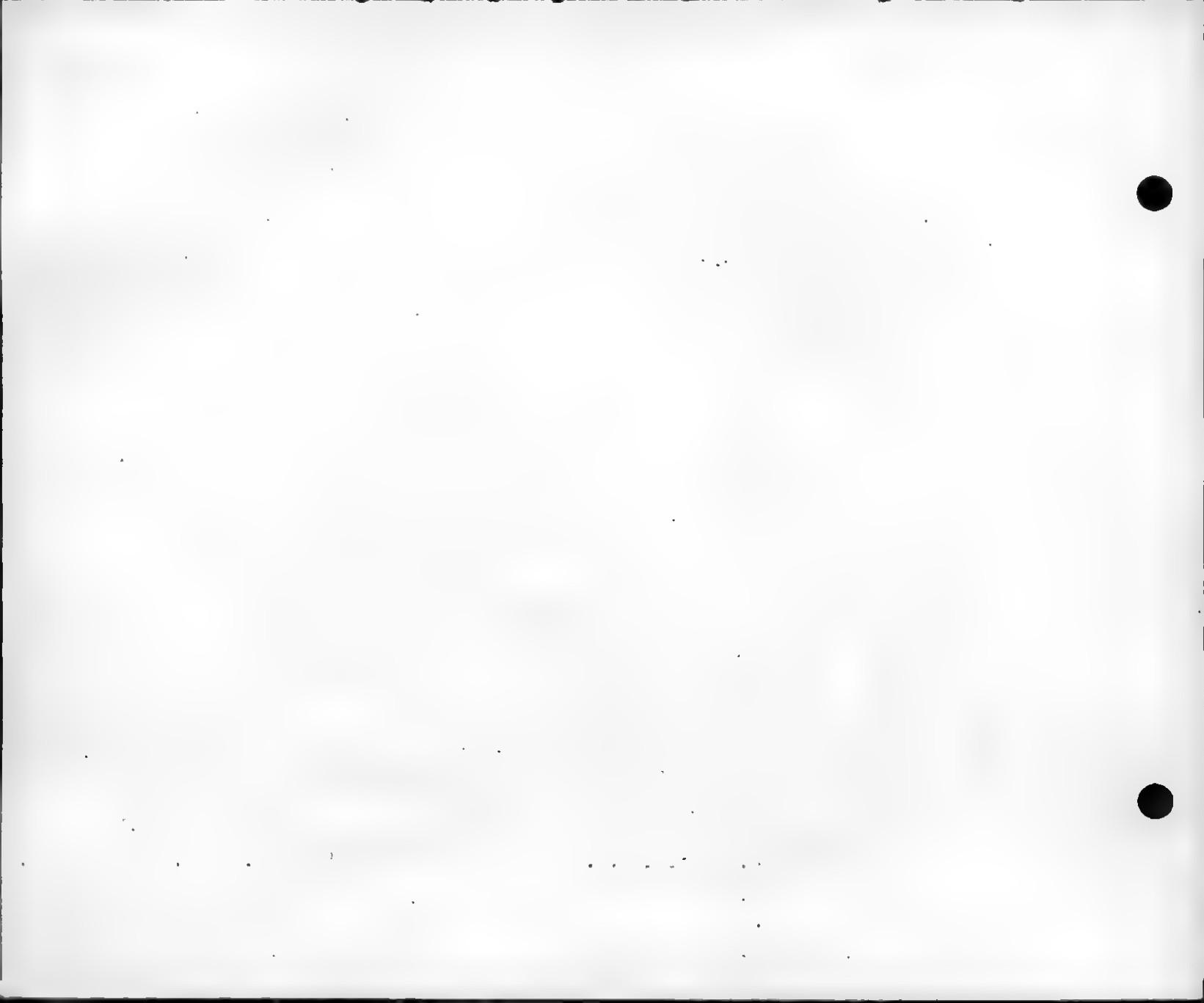
1 PLACE OF DEATH a COUNTY <b>Prince George's</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN Tb <b>DOA</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e STREET ADDRESS <b>12614 Kinder Place</b>	
3 NAME OF DECEASED (Type or print) <b>ELLEN ANN LEININGER</b>		4 DATE OF DEATH Month Day Year <b>3 31 1966</b>	
S SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <b>Never married</b>	8 DATE OF BIRTH <b>3-17-1964</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11b KIND OF BUSINESS OR INDUSTRY <b>Child</b>	
11c BIRTHPLACE (State or foreign country) <b>Virginia</b>		12c CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Theodore C. Leininger</b>		14 MOTHER'S MAIDEN NAME <b>Annette L. Thas</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>None</b>	
17 INFORMANT <b>Theodore C. Leininger, Pl., Bowie, Md.</b>		Address <b>12614 Kinder</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laceration of brain</b>		INTERVAL BETWEEN ONSET AND DEATH	
X 164 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO Skull fracture		Minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Passenger of car involved in head-on collision.</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>10:40 a.m. 3-31-1966</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <b>Rt. 450, 127 ft. east of Race Track Rd.,</b> 20f BOWIE, MD. (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>3-31-66</b>	
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe, M.D. Riverdale, Md.</b>	
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Apr. 4, 1966</b>	
23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Creswell Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Lancaster City, Penn.</b>	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., Riverdale, Md.</b>		25a REGISTRATION NUMBER <b>APR 4 1966</b>	
		25b REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item # Film # 311118											
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE			c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Prince Georges MARYLAND			Maryland Prince Georges			Jefferson Heights			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 8 days											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital											
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year								
James Lewis			March 13 1966								
5. SEX Male Negro			6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH 15 Oct., 1925		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			10b. KIND OF BUSINESS OR INDUSTRY			9. AGE (In years last birthday) 89 yrs.			11. BIRTHPLACE (County & State, or foreign country) Washington D.C. U.S.A.		
13. FATHER'S NAME James Lewis			14. MOTHER'S MAIDEN NAME Elsie ?						12. CITIZEN OF WHAT COUNTRY? Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
									Carcinoma Bronchogenic Carcinoma, left upper lobe.		
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						INTERVAL BETWEEN ONSET AND DEATH		
20c. TIME OF INJURY Month, Day, Year 1966 a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 5, 1966, to March 13, 1966, that <input type="checkbox"/> (we) last saw the deceased alive on March 13, 1966, and that death occurred at 5:05 PM, from the causes and on the date stated above.											
22a. SIGNATURE Edwin J. Jensen									22b. DATE SIGNED 3/15/66		
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22d. ADDRESS Prince George's Genl. Hosp. Cheverly Md.		
23a. BURIAL / CREMATION, REMOVAL (Specify) 3-16-1966			23b. DATE THEREOF 3-16-1966			23c. NAME OF CEMETERY OR CREMATORIUM Lincolne Mem Cemetery			23d. LOCATION (City, town or county) Baltimore, Md. (State)		
24. FUNERAL DIRECTOR Henry S Washington & Sons			ADDRESS 4925 Nearn Ave, NE			25a. REC'D BY REGISTRAR D.M.A.R. 18 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1  
 M  
 04227  
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If this day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e STREET ADDRESS 115 Livingston Road	
3 NAME OF DECEASED (Type or print) First Johnnie Middle N.E.I. Last Lewis		4 DATE OF DEATH Month March Day 26 Year 1966	
S SEX male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	NEVER MARRIED DIVORCED
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8 DATE OF BIRTH Feb. 28, 1910	
10b KIND OF BUSINESS OR INDUSTRY		9 AGE (In years last birthday) 56 yrs	
13. FATHER'S NAME W.M. LEWIS		11 BIRTHPLACE (State or foreign country) PEMBROKE, N.C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		12 CITIZEN OF WHAT COUNTRY? HATTIE LEWIS	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushing injury of skull</u> <u>1234</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in rt. front seat of car which went off road			
20c. TIME OF INJURY Month, Day, Year 5:02 P.M. 2-26-66		20d. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Md. Ht. 210 near Old Fort Rd., Friendly, P.G.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accidents <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> FAX 301-455-5100, Street, city, town, or county Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-2-66	
23c. NAME OF CEMETERY OR CREMATORIAL ST. PAUL'S AME CEM		23d. LOCATION (City or Town) (County) (State) OXON HILL MD.	
24. FUNERAL DIRECTOR ROBERT G. MASON CO. INC. WASH. D.C.		25a. ADDRESS 2500 NICHOLS AVE SE	
		25b. RECEIVED BY REGISTRAR MAR 31 1966	
		25c. DEPUTY'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 04221

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 18 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3825 Rectory Lane				d. STREET ADDRESS 3825 Rectory Lane				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Anna Belle Gray Lloyd		First	Middle	Lost	4. DATE OF DEATH March 15,	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1874	9. AGE (In years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Thomas Putnam Gray			14. MOTHER'S MAIDEN NAME Harriet Amelia Headlee					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Mrs. H. Lee Lewis- Same as Item #2.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Congestive Failure Atherosclerosis CV Disease				INTERVAL BETWEEN ONSET AND DEATH 10 days 15 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Mar 15, 1966, to 15 Mar, 1966, that I last saw the deceased alive on Mar 15, 1966, and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Robert B. Sascer M.D. DATE SIGNED 3/15/66								
PHYSICIAN'S NAME (Type) Robert B. Sascer, M.D.		Upper Marlboro, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/66		22c. NAME OF CEMETERY OR CREMATORIUM Holy Trinity Cemetery		22d. LOCATION (Cty., town, or county) Collington, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home		ADDRESS Upper Marlboro, Maryland		24a. REC'D BY REGISTRAR MAR 23 1966		24b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100% - 10%

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please return carbon paper, pages 1 and 2, to the State Dept. of Health prior to burial, cremation, or removal, and in all cases, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

04221

**1. PLACE OF DEATH**

a. COUNTY  
Prince Georges

b. CITY OR TOWN (if out'side corporate limits, write RURAL and give nearest town)  
Hyattsville

c. LENGTH OF STAY IN 16  
6 months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  
8910 Riggs Road

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)

a. STATE Maryland b. COUNTY Prince George's

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  
Hyattsville

**3. NAME OF DECEASED** (Type or print)  
(MOTHER MARY JOSEPH, Midd., R.J.M.)  
Rose Genevieve

**4. DATE OF DEATH**  
Loesch March 4 1966

**5. SEX**  
F

**6. COLOR OR RACE**  
White

**7. MARRIED**  **NEVER MARRIED**   
WIDOWED  DIVORCED

**8. DATE OF BIRTH**  
June 10, 1917

**9. AGE (in years last birthday)**  
48 yrs.

**10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)  
Teaching

**10b. KIND OF BUSINESS OR INDUSTRY**  
Religious Community

**11. BIRTHPLACE** (County & State, or foreign country)  
Brooklyn, New York

**12. CITIZEN OF WHAT COUNTRY?**  
U.S.A.

**13. FATHER'S NAME**  
Joseph Loesch

**14. MOTHER'S MAIDEN NAME**  
Catherine Blatz

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give rank or date of service)  
No

**16. SOCIAL SECURITY NO.**

**17. INFORMANT**  
None Mother Mary Armand 8910 Riggs Rd. Hyattsville

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)  
15 = 3 DUE TO  
Adenocarcinoma, sigmoid, with generalized metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b)  
(c)

**19. WAS AUTOPSY PERFORMED?**  
YES  NO

**20. ACCIDENT WAS UNDERLYING**  **OR CONTRIBUTING**  **CAUSE OF DEATH** (If either, notify medical examiner)  
None

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)  
None

**20c. TIME OF INJURY** Month, Day, Year  
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
p.m. 19 White Not White at work  at work

**21. I certify that (I) (this) attended the deceased from Sept. 1965 to March 4, 1966, that (I) (we) last saw the deceased alive on Mar. 4, 1966, and that death occurred at 7:40 P.M. from the causes and on the date stated above.**

**22a. SIGNATURE**  
John R. Goodson

**22b. DATE SIGNED**  
Mar. 4, 1966

**22c. PHYSICIAN'S NAME (Type)**  
James R. Goodson, M.D.

**22d. ADDRESS**  
1746 K St. 1, b. Washington D.C. 20006

**23a. BURIAL, CREMATION, REMOVAL (Specify)**  
BURIAL 3-7-66

**23b. DATE THEREOF**

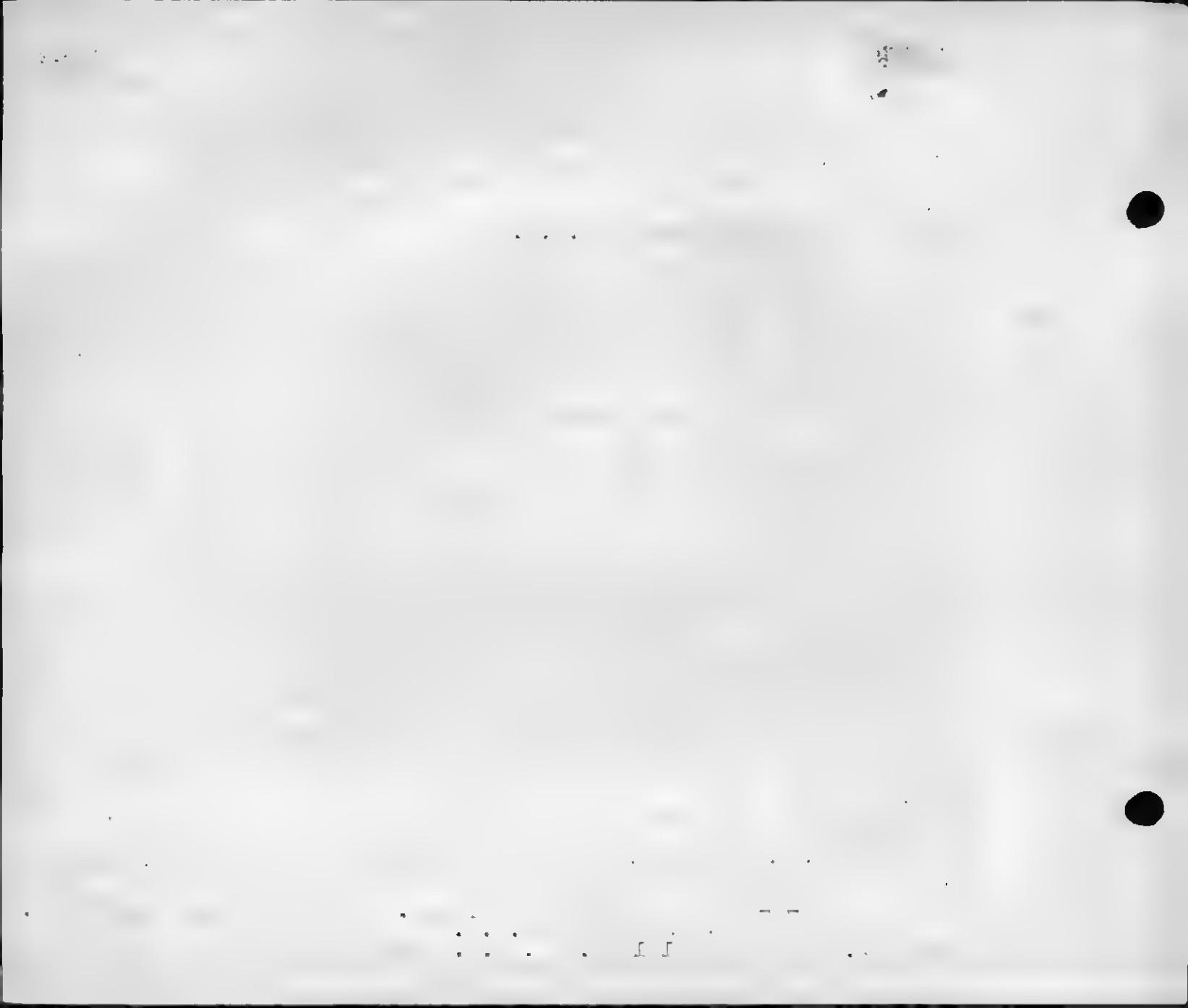
**23c. NAME OF CEMETERY OR CREMATORIAL**  
REGINA CONVENT CEM.

**23d. LOCATION (City, town or county) (State)**  
HYATTSVILLE MARYLAND.

**24. FUNERAL DIRECTOR'S SIGNATURE**  
FRANCIS J. COLLINS ADDRESS WASH. D.C.  
3821 14TH. ST. N.W.

**25a. REC'D BY REGISTRAR**  
M.R. 8 15-3

**25b. REGISTRAR'S SIGNATURE**  
J. Collins, Jr.



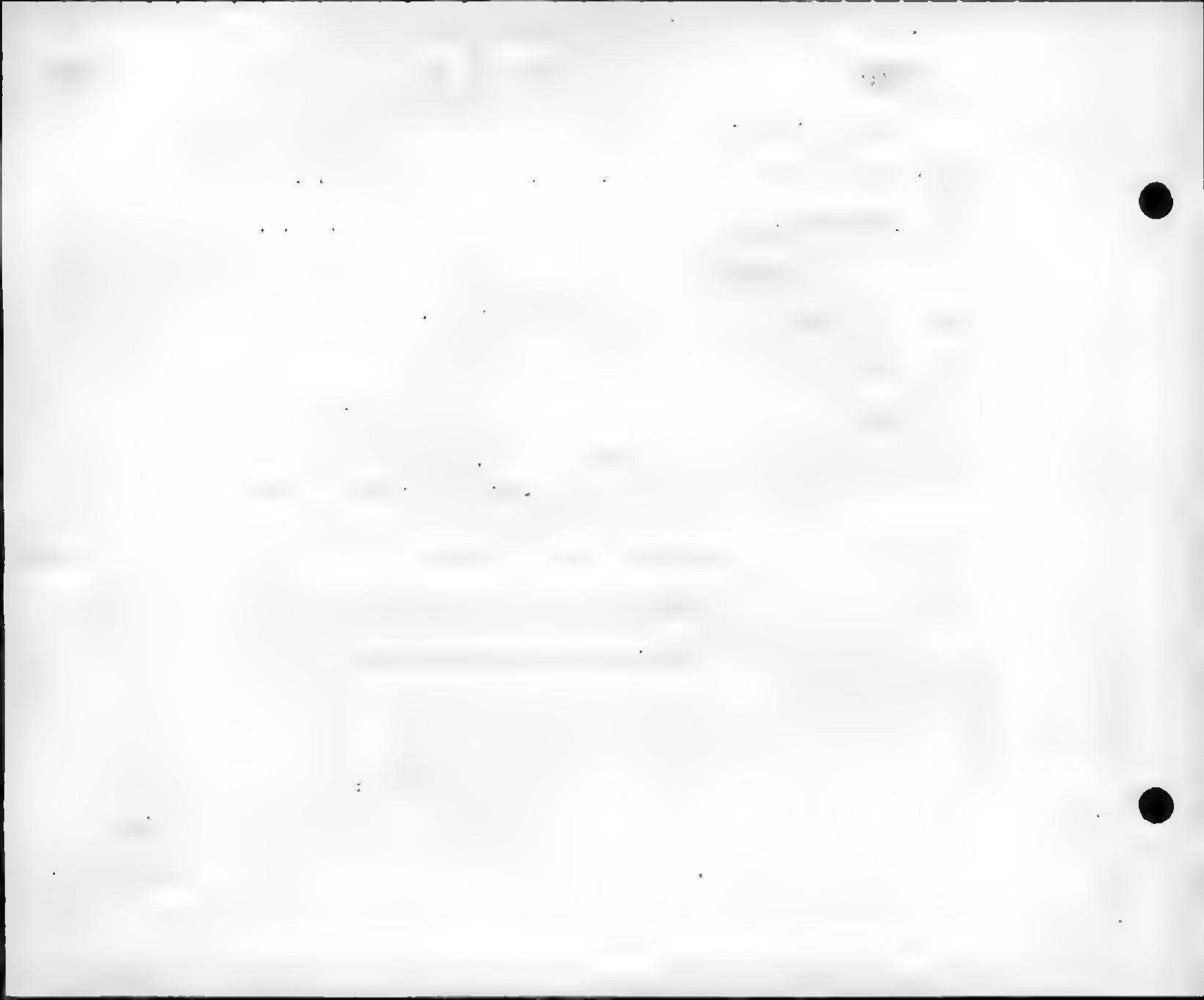
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film 46377-2/66

**CERTIFICATE OF DEATH** 114222

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>	c. LENGTH OF STAY IN lb <b>2 yr. 6 mo.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>2208 12th Pl., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William A. Logan</b>	First	Middle	Last
4. DATE OF DEATH <b>3 - 20 1966</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>4/1/1896</b>	9. AGE (In years last birthday) <b>79 69 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>houseman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jack Logan</b>		14. MOTHER'S MAIDEN NAME <b>Polly Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>has none</b>	
17. INFORMANT <b>decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>recurrent cerebrovascular accident, probably right thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last <b>cerebral arteriosclerosis</b>		unknown	
DUE TO <b>generalized arteriosclerosis</b>		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>right and left cerebrovascular accidents, historical</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Glenn Dale</b> (County) <b>D.C.</b> (State) <b>MD</b>			
21. I certify that <b>I</b> (this hospital) attended the deceased from <b>9/9/1963</b> to <b>3/20/1966</b> , that <b>I</b> (we) last saw the deceased alive on <b>3/20/1966</b> , and that death occurred at <b>1:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/20/66</b>
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>3/30/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>ANATOMICAL BOARD</b>
23d. LOCATION (City or Town) <b>Washington, D.C.</b>		(County) <b>D.C.</b> (State) <b>MD</b>	
24. FUNERAL DIRECTOR <b>Carl J. Gutfreund</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>MAR 31 1966</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

PRINCE GEORGE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HYATTSVILLE

c. LENGTH OF STAY IN IB

1 month

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Carroll Manor 4422 LaSalle Rd Hyattsville, Md.

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Francia

J. Loomans

4. SEX

M

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

JUNE 28 1885

80 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrical Engineer Electrical engineer Oosterhout-Netherlands

13. FATHER'S NAME

ADRIAN LOOYMAN

14. MOTHER'S MAIDEN NAME

JEANETTE DE GROOT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or grade or service)

No

11. BIRTHPLACE (County &amp; State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

CORONARY THROMBOSIS c Myocardial

4201

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.DUE TO myocardial

(b) Arteriosclerotic heart disease

DUE TO

(c)

Address

4422 LaSalle Rd.  
Hyattsville, Md.INTERVAL BETWEEN  
ONSET AND DEATH

One day

3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES  NO 20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 20d. INJURY OCCURRED  
p.m. 19 While at work  Not While at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 3-23 1966 to 3-31 1966, that (I) (we) last saw the deceased alive on 3-28 1966, and that death occurred at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Thomas F. Collins  
M.D.ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS. DATE SIGNED  
3-31-66

22c. PHYSICIAN'S NAME (Type)

THOMAS F COLLINS

22d. ADDRESS  
322 H. Street, N.E. Washington DC

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF April 2, 1966

23c. NAME OF CEMETERY OR CREMATORIALynden Cemetery

23d. LOCATION (City, town or county) Baltimore Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur Walters

ADDRESS 254 Gaithers St. N.W.

25a. REC'D BY REGISTRAR APR 4 1966

25b. REGISTRAR'S SIGNATURE j Charles Judge

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

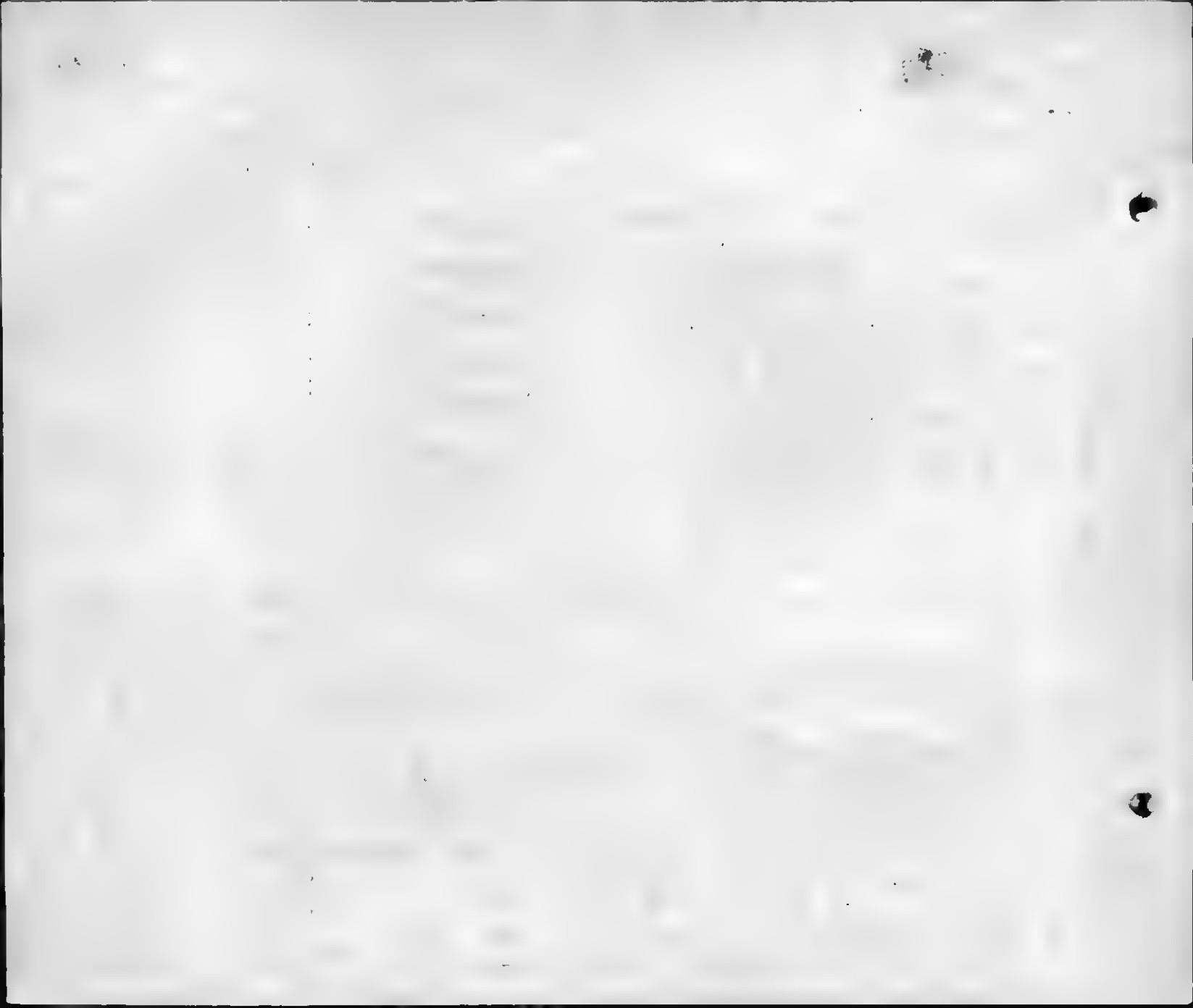
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

2233

114223

VR A15  
1SM 7-62



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

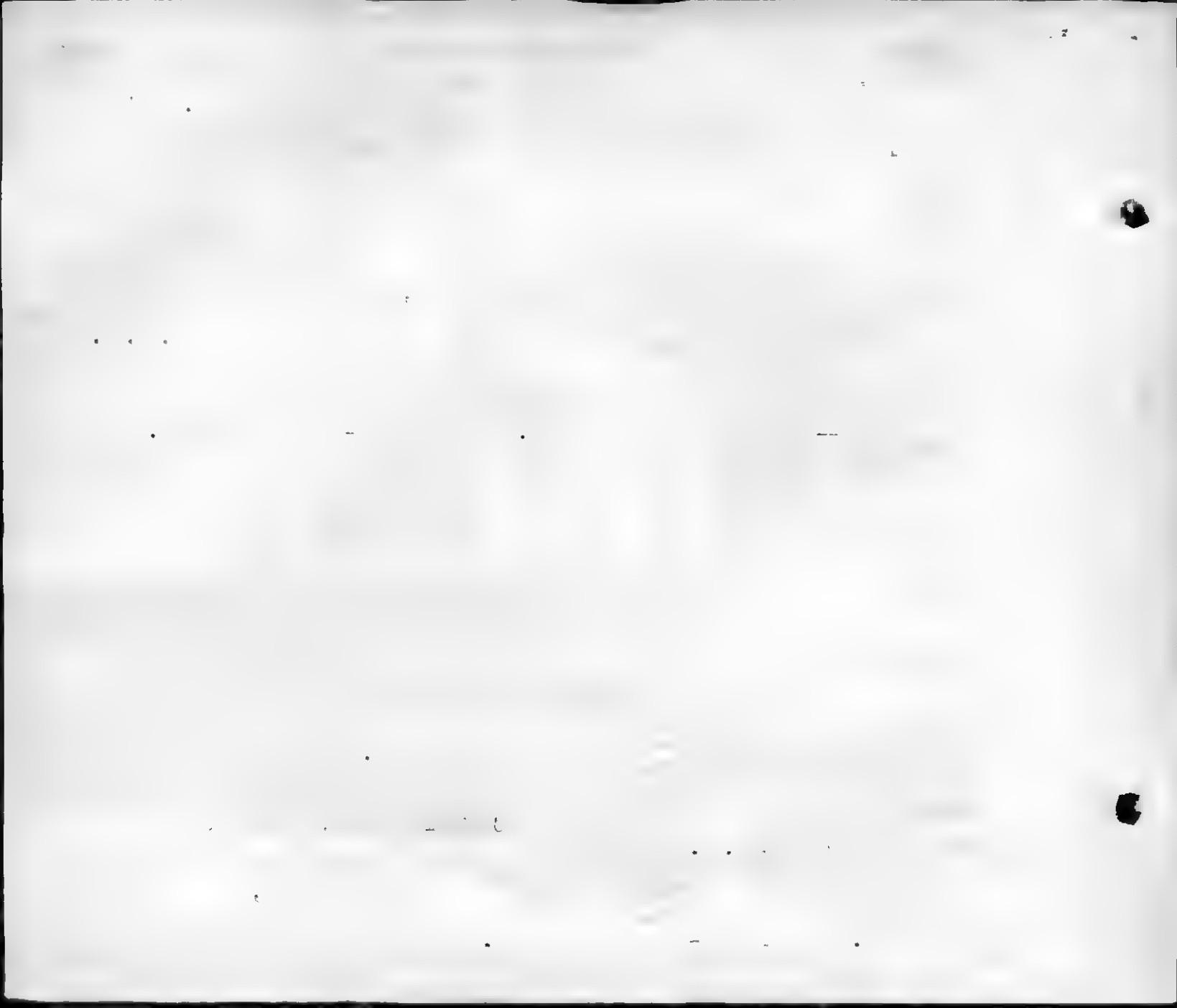
Reg. Dist. No.

04224

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN lb 3 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6905 Adel Street			d. STREET ADDRESS 6905 Adel Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Edward Middle Henry Last Lusby	4. DATE OF DEATH Month March Day 23, Year 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 29, 1880	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Clinton, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Henry Lusby		14. MOTHER'S MAIDEN NAME Elizabeth Ann Goddard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Georgia Sacra- Same as Item #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 16 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/10</i> , 19 <i>66</i> , to <i>3/23</i> , 19 <i>66</i> , that I last saw the deceased alive on <i>3/20</i> , 19 <i>66</i> , and that death occurred at <i>4:25 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>6124 Central Avenue, Capitol Heights, Maryland.</i>			
ACTUAL PHYSICIAN <i>Peter Duus, M.D.</i>		DATE SIGNED <i>3/23/66</i>			
PHYSICIAN'S NAME (Type) Peter Duus, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/66		22c. NAME OF CEMETERY OR CREMATORIUM Epiphany Cemetery	
22d. LOCATION (City, town, or county) Forestville,		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home—Upper Marlboro, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAR 29 1966	
				24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

10 HOSPITAL OR ATTENDING PHYSICIAN:		The law requires that the death certificate be executed within 24 hours after death.											
Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.													
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PrinceGeorges General Hospital</b>		d. STREET ADDRESS <b>3414 40th Place</b>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED (Type or print)</b> <b>First</b> <b>Middle</b> <b>Last</b> <b>Norman Luskey</b>		<b>4. DATE OF DEATH</b> <b>MARCH 17 1966</b>											
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>Sep.</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10 Nov., 1907</b>		<b>9. AGE (In years last birthday)</b> <b>58 yrs.</b>		<b>IF UNDER 1 YEAR</b> <b>Months Days Hours Min.</b>			
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Steamfitter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bulding</b>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>Washington D C</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Elvin M Luskey sr</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Alice Lanham</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)</b> <b>---</b>		<b>16. SOCIAL SECURITY NO.</b> <b>577-09 9520</b>		<b>17. INFORMANT</b> <b>Elsie C Luskey</b>		<b>Address</b> <b>Washington D. C.,</b>							
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Coronary Thrombosis</i> <span style="float: right;">(INTERVAL BETWEEN ONSET AND DEATH 3 days)</span> <i>420/</i> <b>DUE TO</b> <b>Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <i>arteriosclerotic Heart Disease</i> <b>DUE TO</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <i>Previous Pulmonary Embolism and atrial fibrillation</i>													
MEDICAL CERTIFICATION		<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>March 14, 1966</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>Cedar Hill Cemetery</b>		<b>20f. (City or town)</b> <b>Suitland</b> <b>(County)</b> <b>Md.</b> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <b>March 14, 1966</b>, to <b>March 17, 1966</b>, that (I) (we) last saw the deceased alive on <b>March 16, 1966</b>, and that death occurred at <b>20AM</b>, from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <i>W H Clements</i> <b>22b. DATE SIGNED</b> <i>March 17, 1966</i>													
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. W. Clements, M.D.</b>		<b>22d. ADDRESS</b> <b>6001-35th Ave. Hyattsville Md</b>											
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)</b> <b>Burial</b> <b>March 18, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Cedar Hill Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> <b>Suitland</b> <b>Md.</b>		<b>(State)</b>							
<b>24. FUNERAL DIRECTOR</b> <b>J. Gasch's Sons</b>		<b>ADDRESS</b> <b>Hyattsville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 21 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>							

mm.

1 M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pen in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

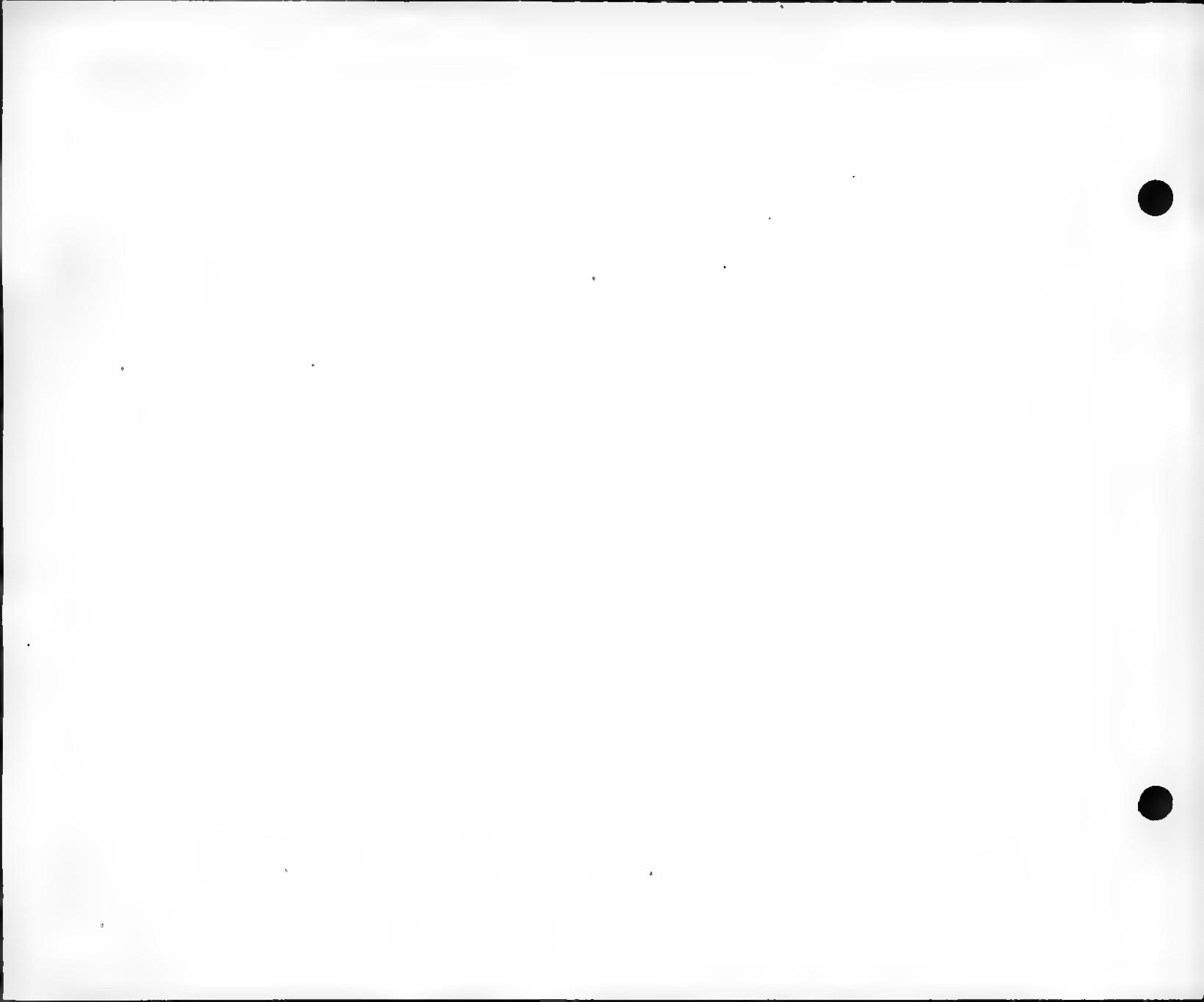
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04234

04226

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b. <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to , give street address) <b>Prince George's Hospital</b>						d. STREET ADDRESS <b>3204 Chillum Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Olivia B. Lutton</b>		First	Middle	Last	4. DATE OF DEATH Month <b>March</b>	Year <b>9 1966</b>	Month Year	Doy Month	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-19-1893</b>	9. AGE (In years last birthday) <b>72 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>	IF UNDER 1 YEAR Days <b>0</b>	IF UNDER 24 HRS Mn <b>0</b>
10. a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		b. KIND OF BUSINESS OR INDUSTRY <b>Railroad employee</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Albert Lutton</b>				14. MOTHER'S Maiden Name <b>Mary Stevenson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Albert Fulton (son)</b>		Address <b>1100 2nd St. 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b>								INTERVAL BETWEEN ONSET AND DEATH MINUTES	
19. DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause <b>Arterio-sclerotic heart disease</b>								unknown	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <b>Riverton Rd.</b>		20f. (City or town) <b>Colmar Manor, Md.</b>		(County) (State) <b>(County) (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/14/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Colmar Manor, Md.</b>		(County) (State) <b>(County) (State)</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

M

04235

04227

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DCA		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Forest Knolls	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 9601 Taylor Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Constantine	Middle (Gust)	Last Namakos
4. DATE OF DEATH	Month 3	Day 16	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 21 May 1882	9. AGE (in years 83 lost birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Restaurant Owner		11. BIRTHPLACE (State or foreign country) Greece	
13. FATHER'S NAME Steve Mamakos		14. MOTHER'S MAIDEN NAME Mary -- (unobtainable)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Lorraine Leathers same as above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH minutes over 20 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
22. DATE SIGNED 3-16-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/19/66	23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.		23e. RECEIVED BY REGISTRAR MAR 18 1966	
24. FUNERAL DIRECTOR The S.H. Hines Co. Washington, D.C.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04236

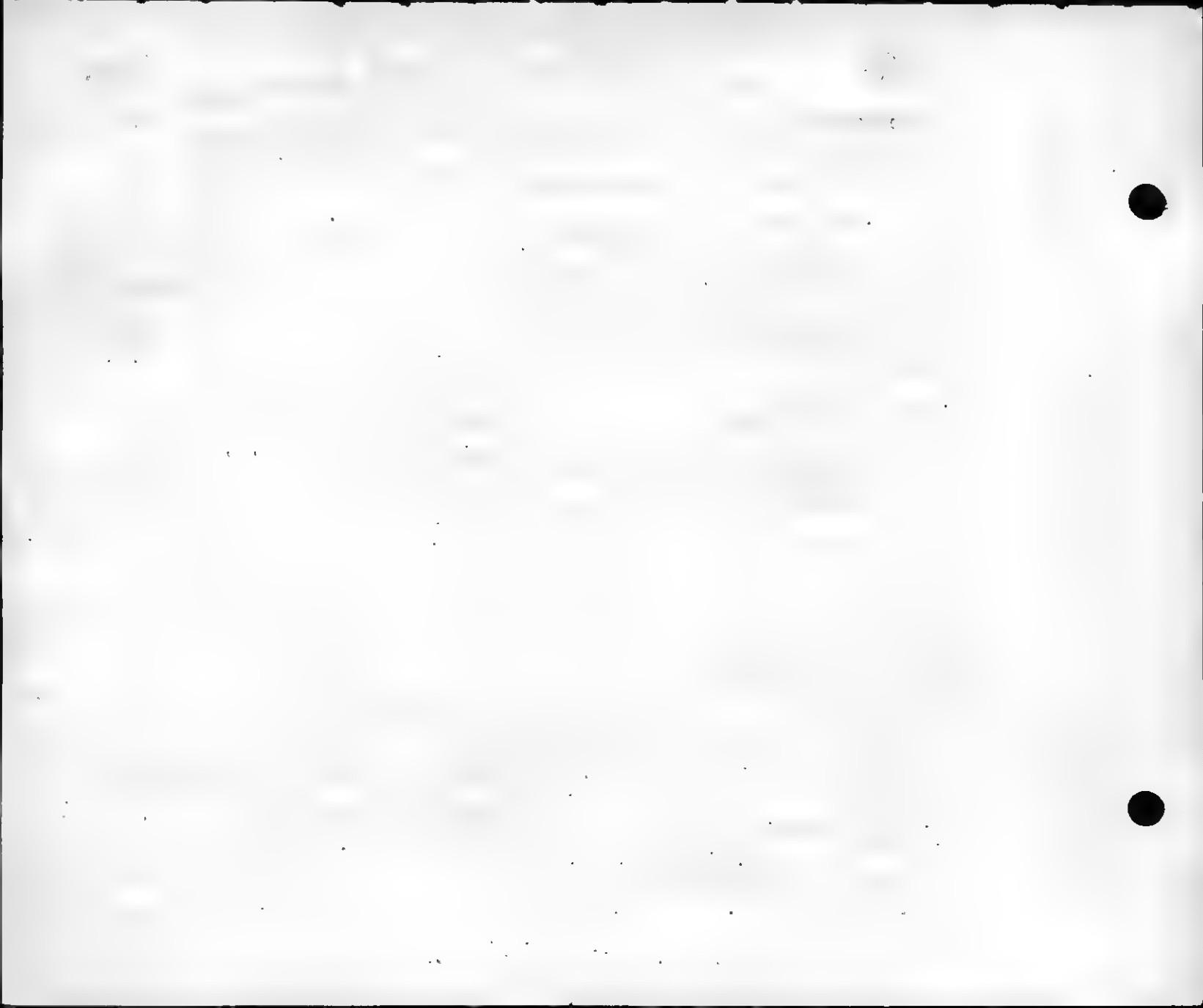
CERTIFICATE OF DEATH

04228

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.		PLACE OF DEATH a. COUNTY		Prince George's Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hyattsville				a. STATE Maryland	
		c. LENGTH OF STAY IN 1b						b. COUNTY Prince George's Montgomery	
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		1400 Ray Road		Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
								d. STREET ADDRESS 1400 Ray Road	
								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LOUIS		Middle ANDREA		Last MANCUSI		4. DATE OF DEATH Month MARCH 9 1966	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1913		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Joseph Mancusi		14. MOTHER'S MAIDEN NAME Josephine Ranaglia							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Esther Mancusi		Address 2 a, b, c, d above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinomatosis				1 year			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		Carcinoma of Colon		1 1/2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from September 1950, to March 9, 1966, that (I) <del>never</del> last saw the deceased alive on March 9, 1966, and that death occurred at 2:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE John F. Brennan, Jr.		22b. DATE SIGNED March 9, 1966							
22c. PHYSICIAN'S NAME (Type) John F. Brennan, Jr.		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1034 TERRY ST. N.E., WASHINGTON, DC.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12 Mar. 1966		23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's		23d. LOCATION (City, town or county) Washington, DC (State)			
24. FUNERAL DIRECTOR Rinaldi Funeral Home, Inc.		ADDRESS N.W., DC		25a. REC'D BY REGISTRAR DATE 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

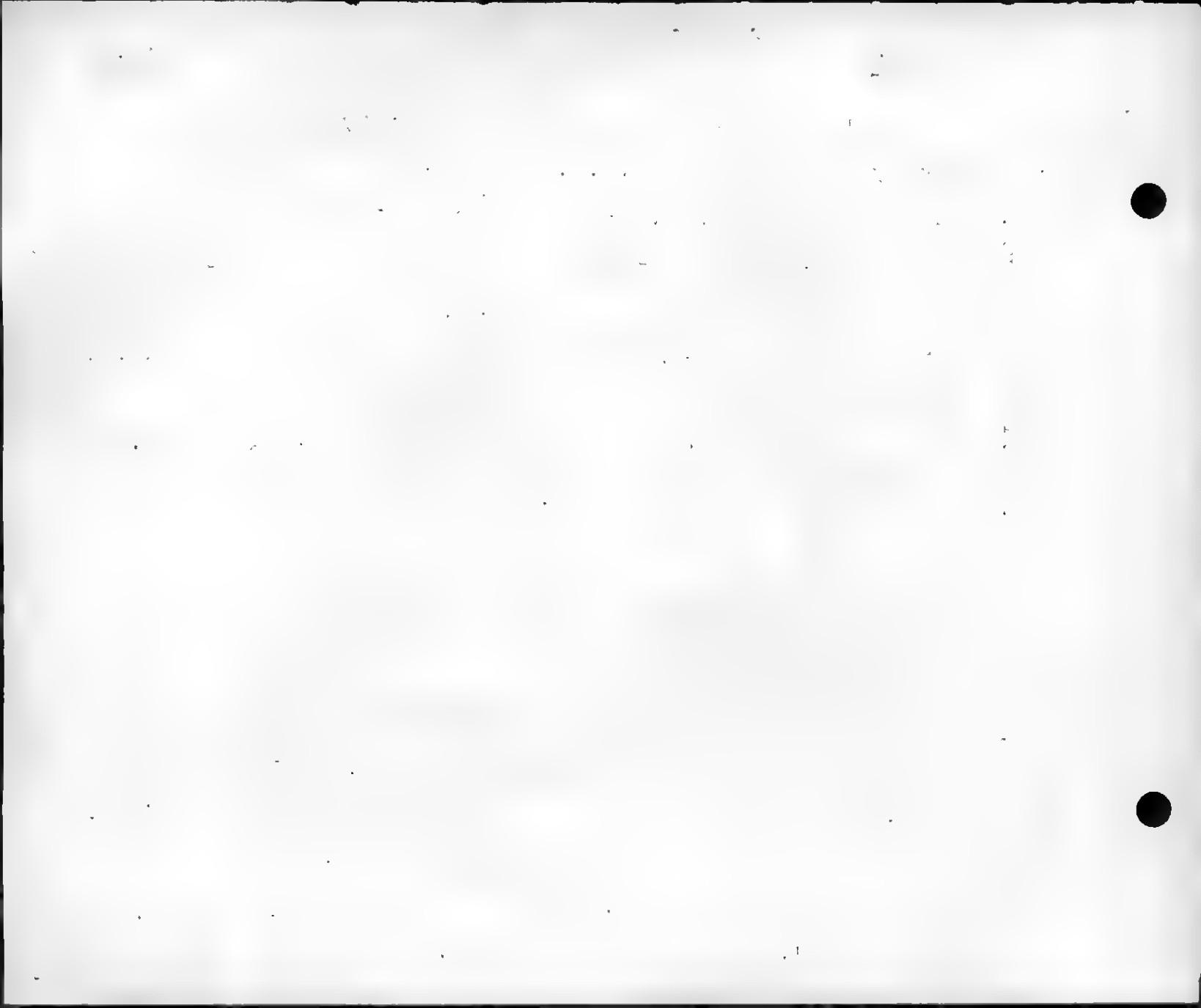


**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Kehoe, Medical Examiner, Notified and approved

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE				3. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Prince George Cheverly				Maryland D. O. A.				Lanham									
Prince George General Hospital								d. STREET ADDRESS 9322 Wyatt Drive									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
JOSEPH Male		Michael		MARSHALL	Sept. 29, 1897	68	March	7, 1966									
5. SEX		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1897	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS Hours	13. IN MIN. Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian				10b. KIND OF BUSINESS OR INDUSTRY Apt. Building				11. BIRTHPLACE (County & State, or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DEC EASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 17. INFORMANT 577 58 7250 Paulina Marshall Same as #2 (wife)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Thrombosis, recurrent Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Atherosclerosis (c)								INTERVAL BETWEEN ONSET AND DEATH Two months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 White at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 3/7, 1966, that (I) (we) last saw the deceased alive on 2/27/66, and that death occurred at 70 M, from the causes and on the date stated above.												22b. DATE SIGNED 5/8/66					
22a. SIGNATURE <i>John W. Lathrop</i>								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1728 Larch Ave NW DC									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/10/66				23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet				23d. LOCATION (City, town or county) (State) Washington D.C.					
24. FUNERAL DIRECTOR				ADDRESS Francis Gasch's Sons Hyattsville, Maryland				25a. REC'D BY REGISTRAR MAR 10 1966				25b. REGISTRAR'S SIGNATURE Charles Judge					



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

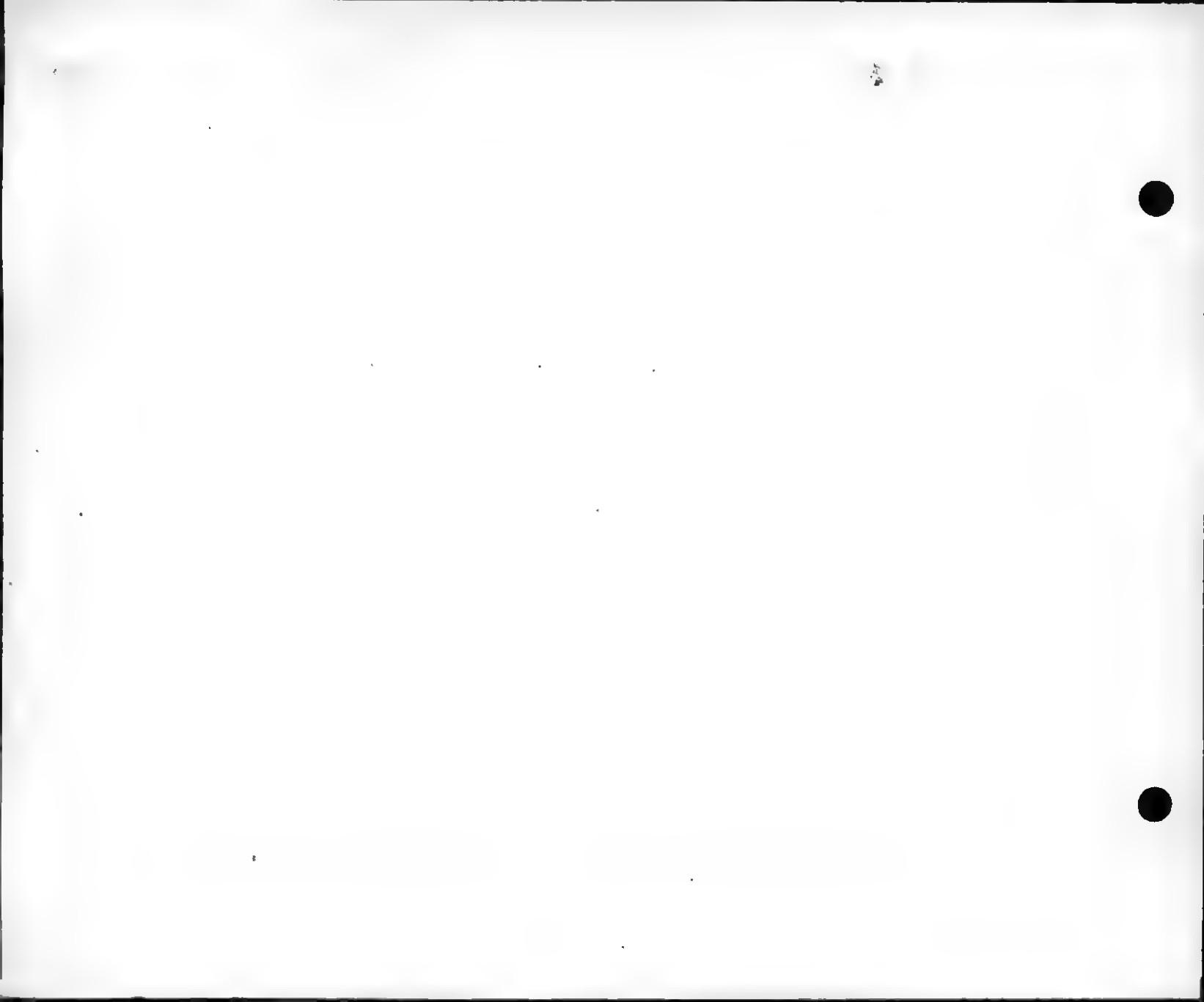
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 3 Film 75 3-21-66 M

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**04233** **04230**

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George</b>	
c LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>625 Sheridan Street</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>LeGrand</b>	Middle <b>Henry</b>	Last <b>Martin</b>
4. DATE OF DEATH	Month <b>3</b>	Month <b>21</b>	Day <b>19</b>
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8b. OCCUPATION (Give kind of work done during last 6 months working life, even if retired) <b>Factory worker</b>		9. DATE OF BIRTH <b>15 April 1885</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Harvey Springs Co</b>		11. BIRTHPLACE (State or foreign country) <b>Racine, Wisconsin</b>	
13. FATHER'S NAME <b>Louis Martin</b>		14. MOTHER'S MAIDEN NAME <b>Alice Young</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>395-12-8533</b>	
17. INFORMANT <b>Mrs Dorothy J. Martin (Same as #2)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH min.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Arteriosclerotic heart disease</b>		over 20 yrs.	
(b) DUE TO <b>Arteriosclerotic heart disease</b>			
(c) DUE TO <b>Arteriosclerotic heart disease</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Racine, Wisconsin</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		22. DATE SIGNED <b>3-21-66</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 24, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Holy Cross Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Racine, Wisconsin</b>	
24. FUNERAL DIRECTOR <b>Jakoma Funeral Home Inc. 254 Carroll St. N.Y.C.</b>		25a. REC'D. BY REGISTRAR DATE <b>MAR 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



Items 18&21 Film G378 7/1 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

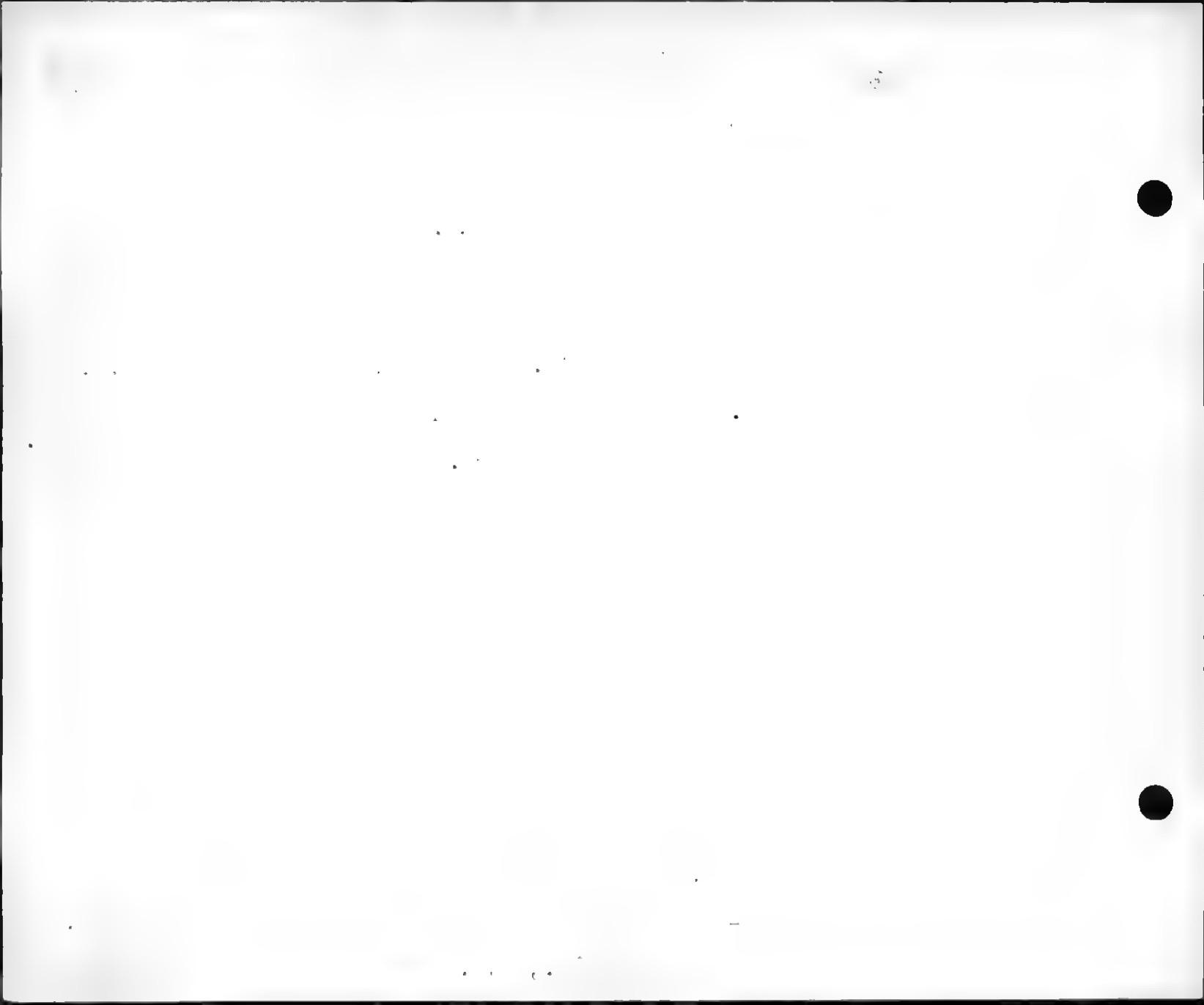
04231

04233

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) b. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS P.O. Box 295	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Samuel N.	Middle Martin	4. DATE OF DEATH 3 28 1966
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED W.DOWED	8. DATE OF BIRTH 12-31-30
9. NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 35 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Gov't.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel A. Martin		14. MOTHER'S MAIDEN NAME Annie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213 24 3558 Mrs. Annie Martin Upper Marlboro	
17. INFORMANT		Address Md. Upper Marlboro	
18. CAUSE OF DEATH (Enter on <input type="checkbox"/> one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Asphyxia		INTERVAL BETWEEN ONSET AND DEATH Moments	
5052 DUE TO Conditions, Tony, which gave rise to immediate cause (a). stating the underlying cause last		(b) Status epilepticus	
(c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
22. DATE SIGNED 3-29-66			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 3-30-66	23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial	23d. LOCATION (City or Town) Landover
24. FUNERAL DIRECTOR Rollins		ADDRESS 4339 Hunt Pl., N.E.	25a. REC'D BY REGISTRAR MAR 31 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



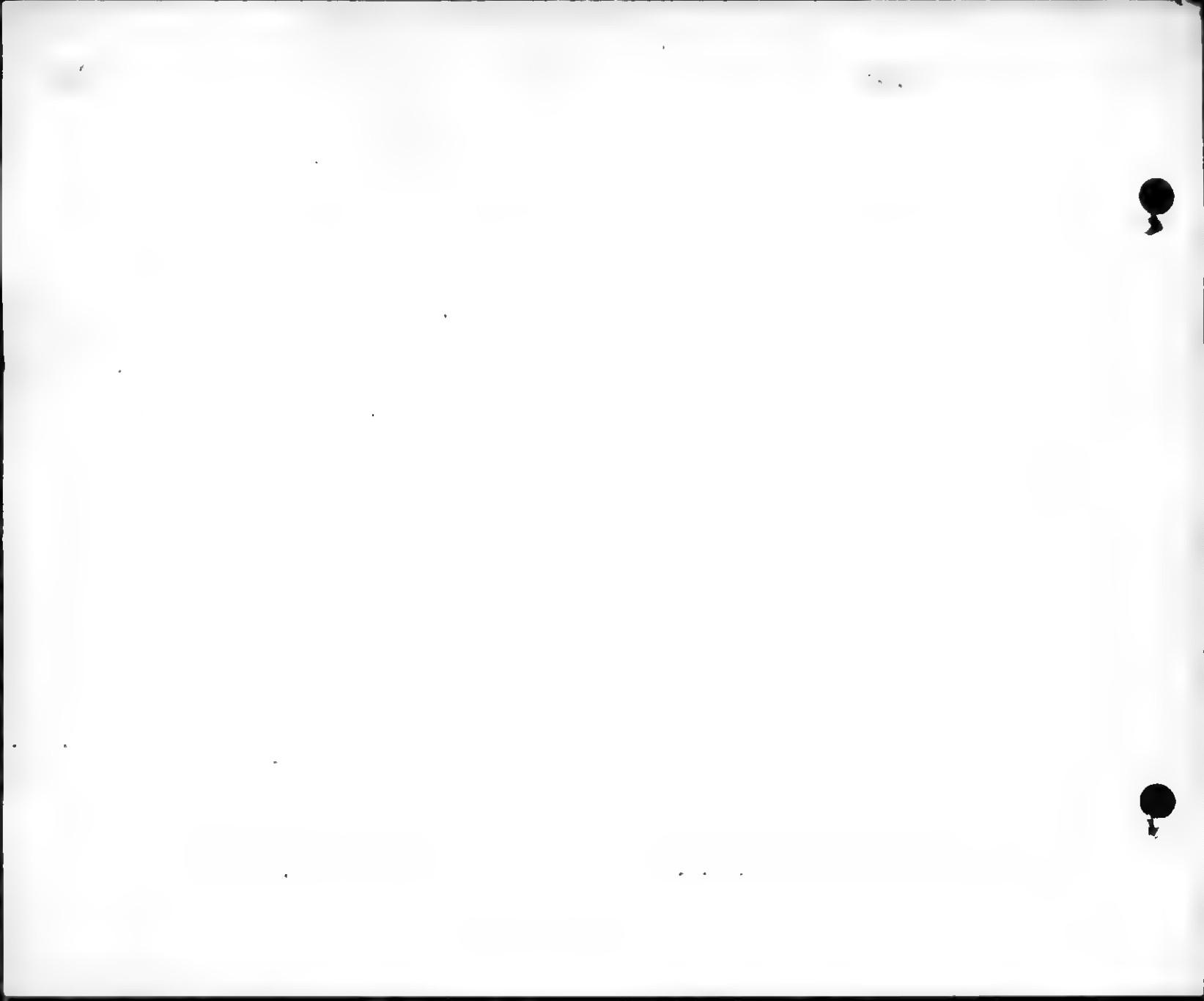
Items 18-21 Film G376 5/16/66 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City delay is necessary, please execute this certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH							04232					
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN b. DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights			d. STREET ADDRESS 800 57th Avenue				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		Firs Frank	Middle Henry	Last Martinelli	4. DATE OF DEATH Month March Day 11 Year 1966							
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 3, 1913	9. AGE (in years 52 b. birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.				
10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Gas Station Emp			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Dominic Martinelli				14. MOTHER'S MAIDEN NAME Fortumato								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII			16. SOCIAL SECURITY NO			17. INFORMANT Bertha M. Martinelli			Address 800 57th Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  1710 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenia 20 years												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Took excessive quantity of sedative synergistic							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3/11 1966			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) (County) (State) Capitol Hgts. Pr. Geo. Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>										22. DATE SIGNED 3-12-66		
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Admiral J. L. (Signature)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-15-66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia						
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Rd Suitland Maryland		25a. REC'D BY REGISTRAR MAR 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						
VR A15ME (5) 6M 1/66												

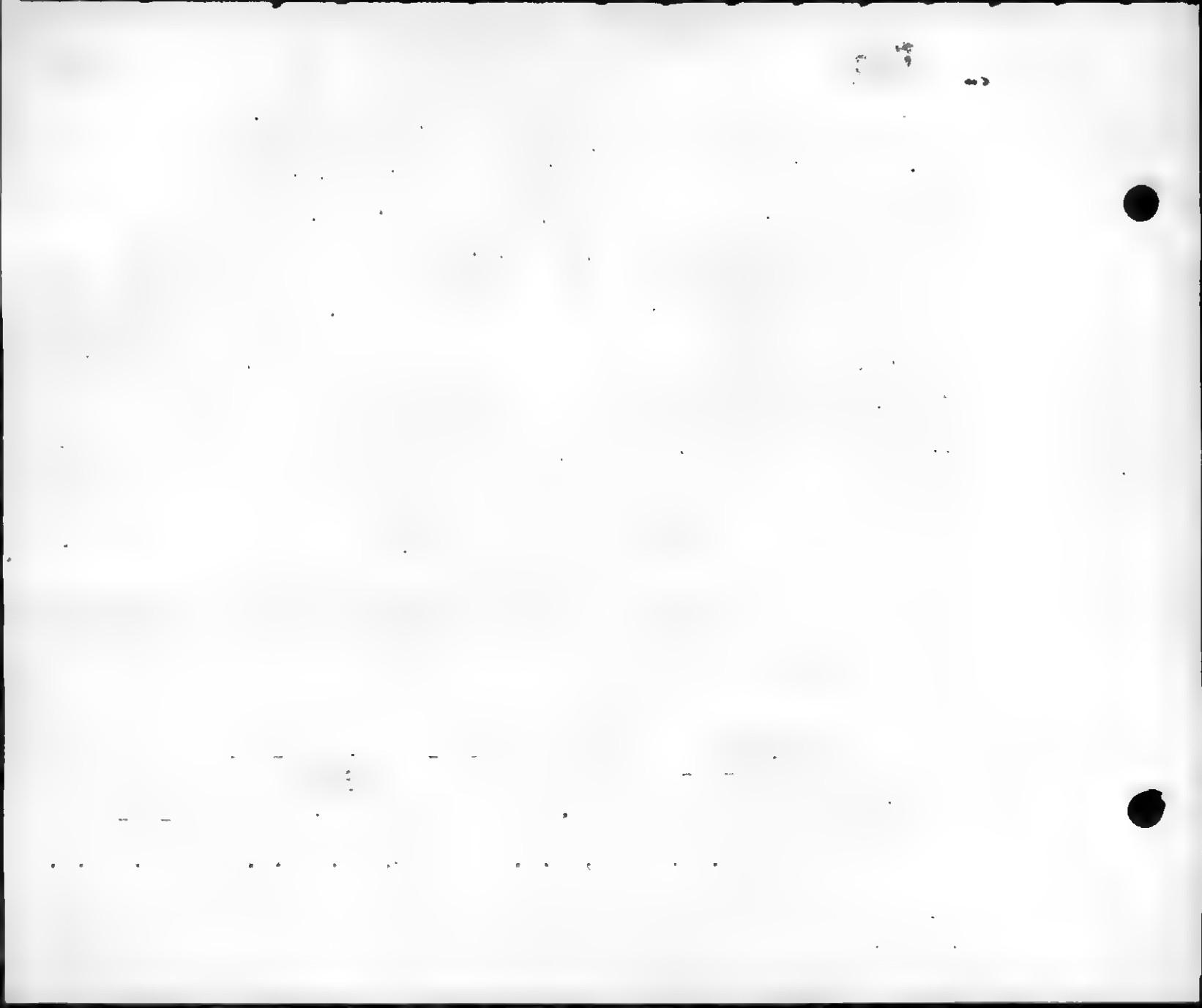


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

**04241** **04233**

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 yrs</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CARROLL MANOR</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF <b>MARGARET G. MATHEWS</b> (Type or print)	First	Middle	Last	
4. DATE <b>DEATH</b>	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-14-1886</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAM STRESS</b>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>79 yrs.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>LCOMN, UTAH</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Henry Griffiths</b>	14. MOTHER'S MAIDEN NAME <b>Euphemia Dock</b>	Address <b>Carroll Manor</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>519-12-9416</b>	17. INFORMANT <b>Dr Magdalena</b>	INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b>  DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Heart Disease</b>  DUE TO (c)				1 Yr. <b>7 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
MEDICAL CERTIFICATION				
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>25th</b>	(County) (State)
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>12-22-</b> , 19 <b>85</b> , to <b>3-14-</b> , 19 <b>66</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>3-13-</b> 19 <b>66</b> , and that death occurred at <b>11:25 AM</b> , from the causes and on the date stated above.				
22a. SIGNATURE <b>Thomas F. Collins</b>	22b. DATE SIGNED <b>3-14-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Collins, M.D.</b>	22d. ADDRESS <b>322 H St., N.E., Wash., D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAR. 18, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>SMITHFIELD CEMETERY</b>	23d. LOCATION (City, town or county) <b>SMITHFIELD, UTAH</b>	(State)
24. FUNERAL DIRECTOR <b>M.W. HYSONG CO.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE		
20M 1/65		DATE <b>MAR 16 1966</b>		



MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

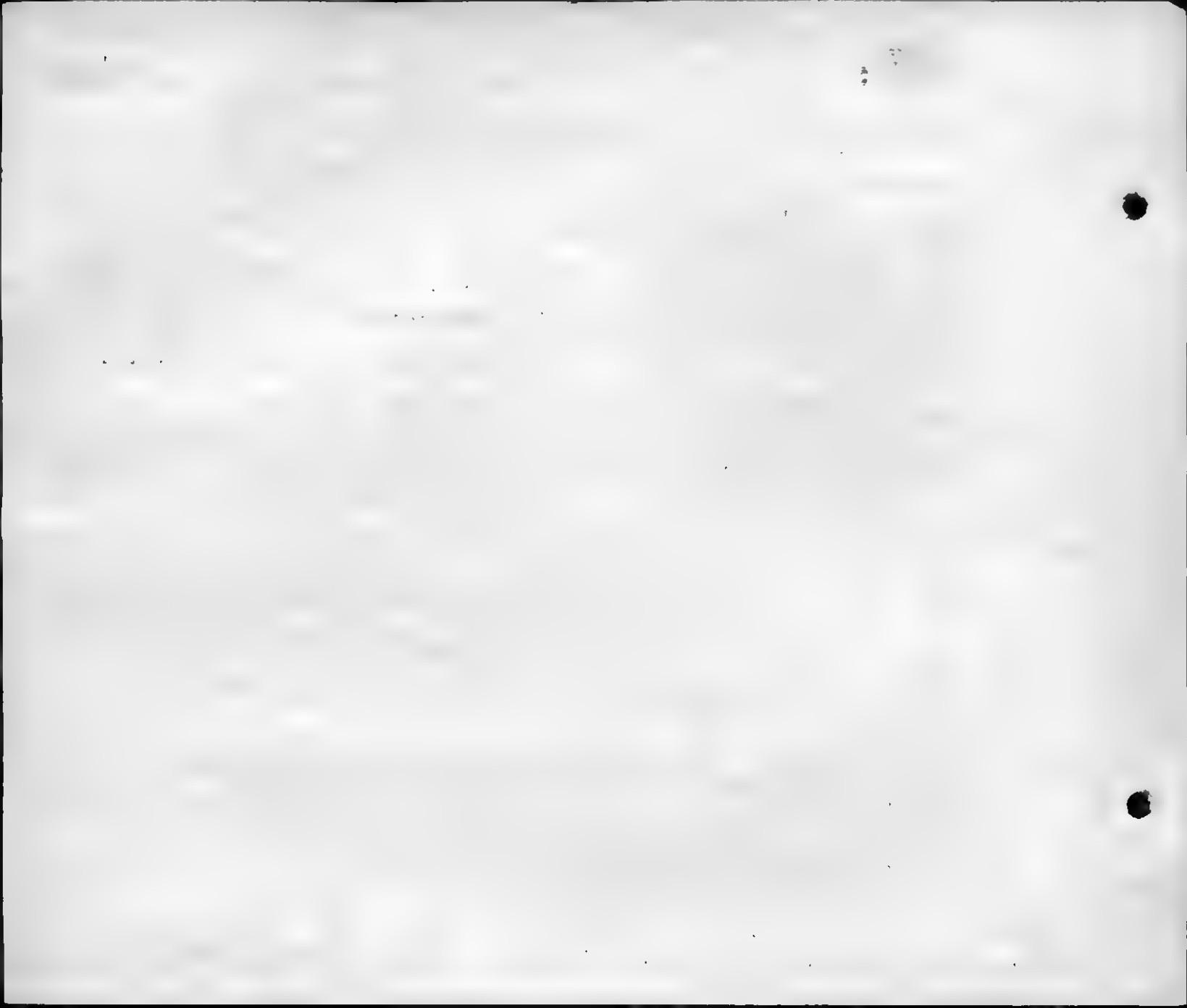
G.242

**TO HOSPITAL** [REDACTED] ATTENDING PHYSICIAN: The law requires that the death certificate be executed [REDACTED] within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and [REDACTED] event, within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Prince George		b. STATE Maryland Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB	
MARYLAND			
c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS District Heights	
Prince George's General Hospital First Middle		8009 Kipling Parkway	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Adelaide		Last Month Day Year	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		1894 72 March 30 1966	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
Housewife		January 15, 1893 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country)	
Housewife		Italy	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME Nicholas Bastiani		14. MOTHER'S MAIDEN NAME Josephine DeRasme	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		Rudy Mattera 8009 Kipling Parkway	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address District Heights	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
4201 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first.		DUE TO (b) Coronary artery heart disease	
DUE TO (c)		7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-4 1966 to 3-29, 1966; that (I) (we) last saw the deceased alive on March 29, 1966, and that death occurred at 7 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 3-30-66	
22a. SIGNATURE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Thos. F. Cheiffield		22d. ADDRESS 3647 3rd St. N.W. Washington, D.C. 20023	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 4/2/66		23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln	
23d. LOCATION (City, town or county) Beadensburg, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300 4th St NE		25a. REC'D BY REGISTRAR APR 4 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

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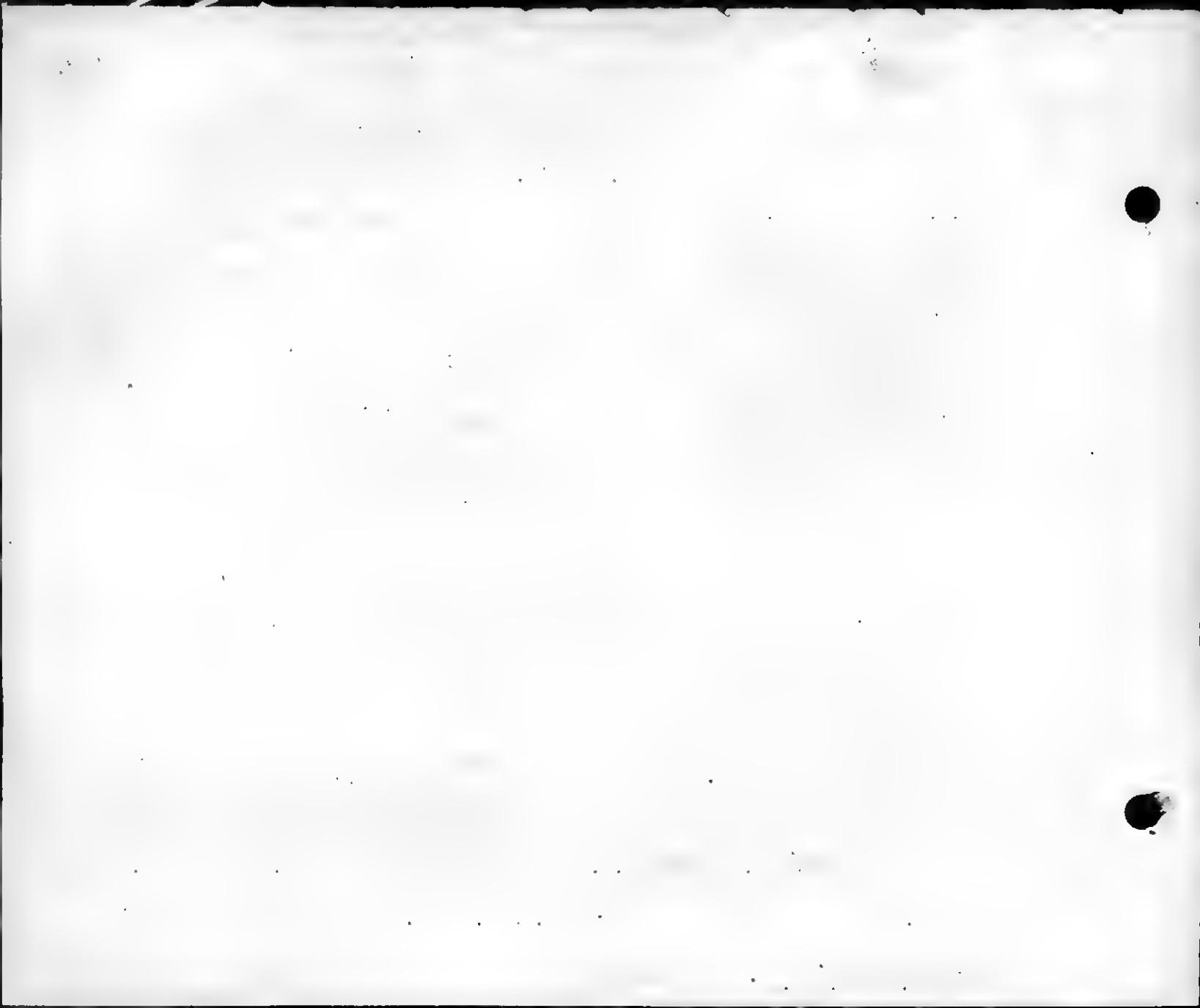
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 hr. 43 min.</b>		a. STATE <b>Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				b. COUNTY <b>Prince George's</b>	
3. NAME OF DECEASED (Type or print) <b>Baby</b>		First <b>Baby</b>	Middle <b>Girl</b>	Last <b>Matthews</b>	4. DATE OF DEATH <b>March 5, 1966</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1966</b>	9. AGE (In years last birthday) <b>yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>	
13. FATHER'S NAME <b>Hilbert Jerome Hebron</b>		14. MOTHER'S MAIDEN NAME <b>Judith Ann Matthews</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. --		17. INFDRMNT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> 196x		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) OUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (c) OUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (d) OUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <b>xx</b> (this hospital) attended the deceased from <b>March 5, 1966</b> , to <b>March 5, 1966</b> , that <b>xx</b> (we) last saw the deceased alive on <b>March 5, 1966</b> , and that death occurred at <b>3:48 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Andrew Aronfy</b>		ATTENDING PHYS. <input type="checkbox"/>	PM MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>3/8/66</b>
22c. PHYSICIAN'S NAME (Type) <b>Andrew G. Aronfy, M.D.</b>		22d. ADDRESS <b>6803 Good Luck Rd. Lanham, Md.</b>			

**HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be retained by the hospital or attending physician.

**Page 5 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

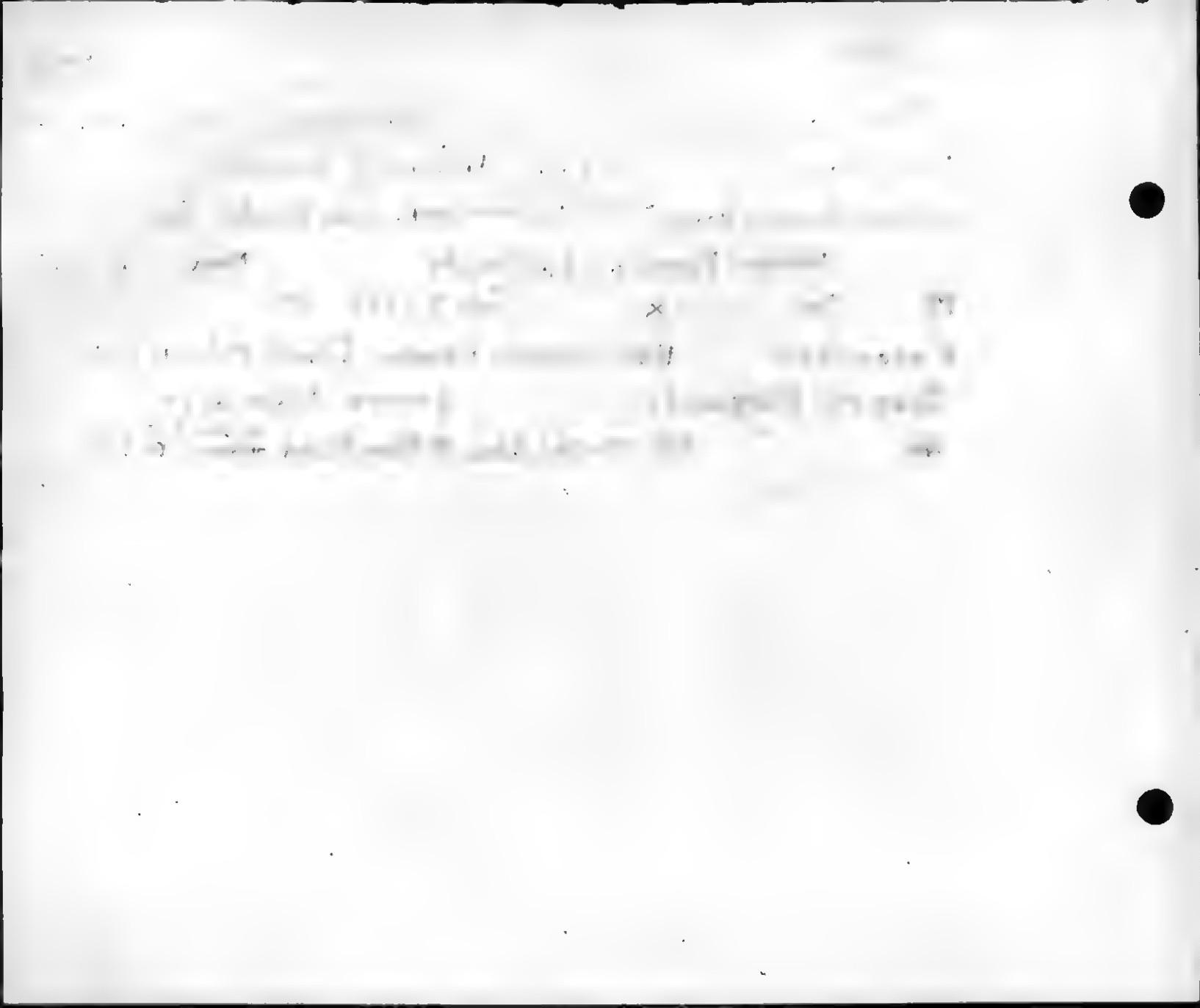
VR A15 (4)  
20M 1/65



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TU FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE							
PRINCE GEORGES MARYLAND				MARYLAND PRINCE GEORGES							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 17 days							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Nursing Home 6600 RIGGS ROAD HYATTSVILLE MD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Henry Brooke Mattingly				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
							MARCH	9	1966		
5. SEX M				6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1880	9. AGE (In years last birthday) 85 yrs.	10. KIND OF BUSINESS OR INDUSTRY Navy Install.	11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				14. MOTHER'S MAIDEN NAME Laura Mattingly							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 220-07-2762 17. INFORMANT Edna M. Blandford Address 2952-2 St. S.E. Apt. 13, WASH. 20, D.C.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH minutes							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Respiratory Arrest							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)				Cerebral Vascular Accident							
DUE TO				2 mos. 5 years.							
DUE TO				Generalized Atherosclerosis							
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				29. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 21, 1966, to March 7, 1966, that (I) (we) last saw the deceased alive on Feb 23, 1966, and that death occurred at 9 <sup>th</sup> M, from the causes and on the date stated above.				22b. DATE SIGNED March 66							
22a. SIGNATURE Name M. Draper				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 911 S. LIVER Spring AVE, SILVER SPRING							
22c. PHYSICIAN'S NAME (Type) H. ROBERT W. DRAPER, M.D.				23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 3/12/1966 23c. NAME OF CEMETERY OR CREMATORIAL Wash National							
24. FUNERAL DIRECTOR				23d. LOCATION (City, town or county) (D. (State)) Suitland, Md							
ADDRESS				25a. REC'D BY REGISTRAR MAR 14 1966 25b. REGISTRAR'S SIGNATURE Charles Judge							
Attn: 131-1101 St. S.E. D.C.											
VR A15 (4) 20M 1/65											



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

03245

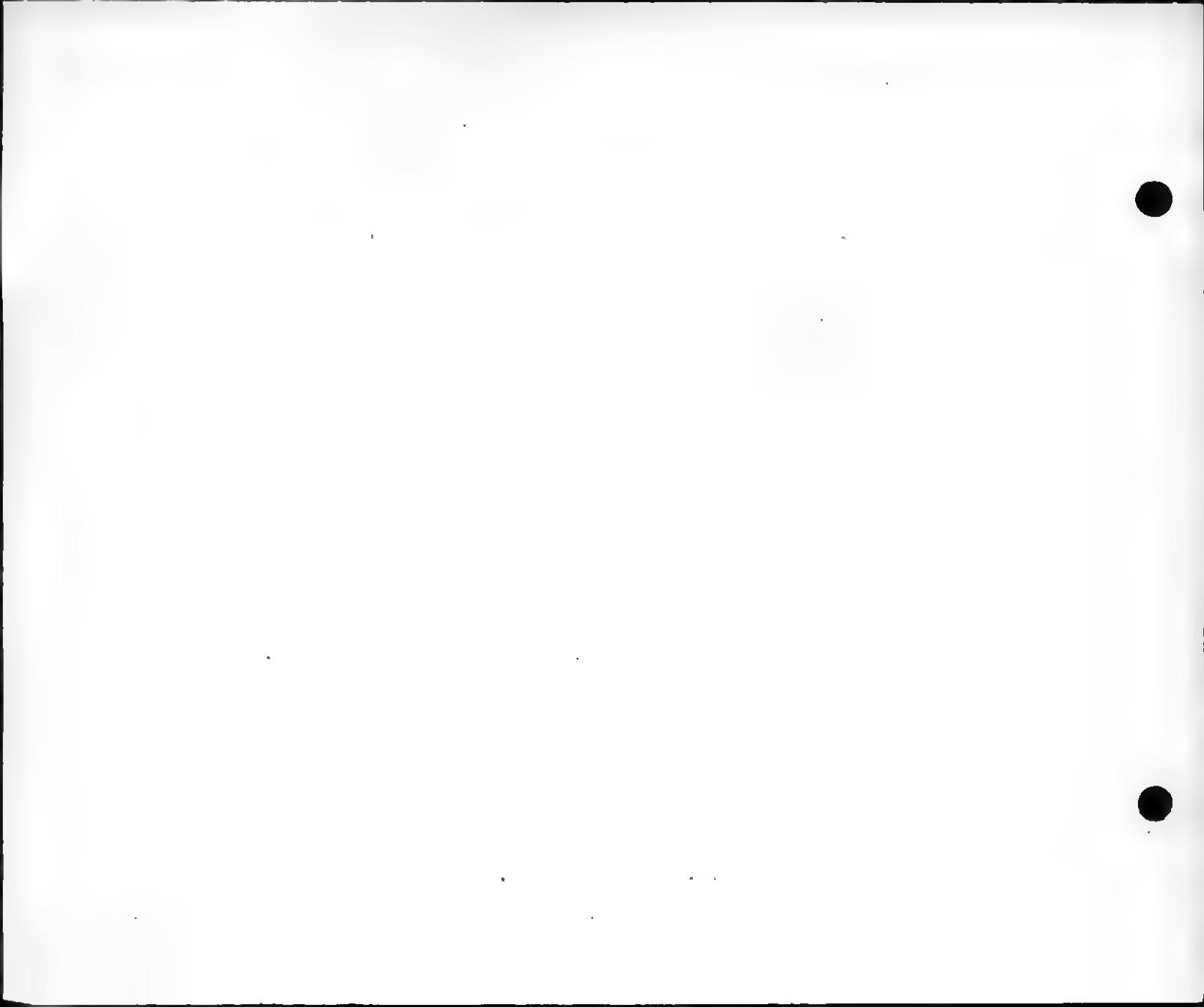
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04237

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3410 39th Avenue</b>		e. STREET ADDRESS <b>3410 39th Avenue</b>	
3 NAME OF DECEASED (Type or print) <b>Edward</b>		First <b>EDWARD</b>	Middle <b>LOUIS</b>
4 DATE OF DEATH Month <b>May</b>	Day <b>30</b>	Month <b>19</b>	Year <b>66</b>
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>12-24-1910</b>
9 AGE (In years lost birthday) <b>55 yrs</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAXI CAB DRIVER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>YELLOW CAB CO.</b>	11 BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	13. FATHER'S NAME <b>EDWARD L. MAY</b>	14. MOTHER'S MAIDEN NAME <b>SYLVIA SEYMOUR</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>
16. SOC. A. SECURITY NO <b>577-16-9989</b>	17. INFORMANT <b>DOROTHY J. RICHARDSON</b>	Address <b>2714 ARCOLA AV LUHEATON, MD</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Poliomyelitis with residual weakness of legs - 40 years.</b>			INTERVAL BETWEEN ONSET AND DEATH minutes
20a. EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19</b>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>RIVERDALE</b>	(County) <b>MARYLAND</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>3-30-66</b>
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>APRIL 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>FORT LINCOLN CEM</b>	23d. LOCATION (City or Town) <b>BLADENSBORG, MD.</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>	ADDRESS <b>DATA APR 4 1966</b>	25a. REC'D BY REG STRR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE



FOR STATE  
HEALTH DEPT.

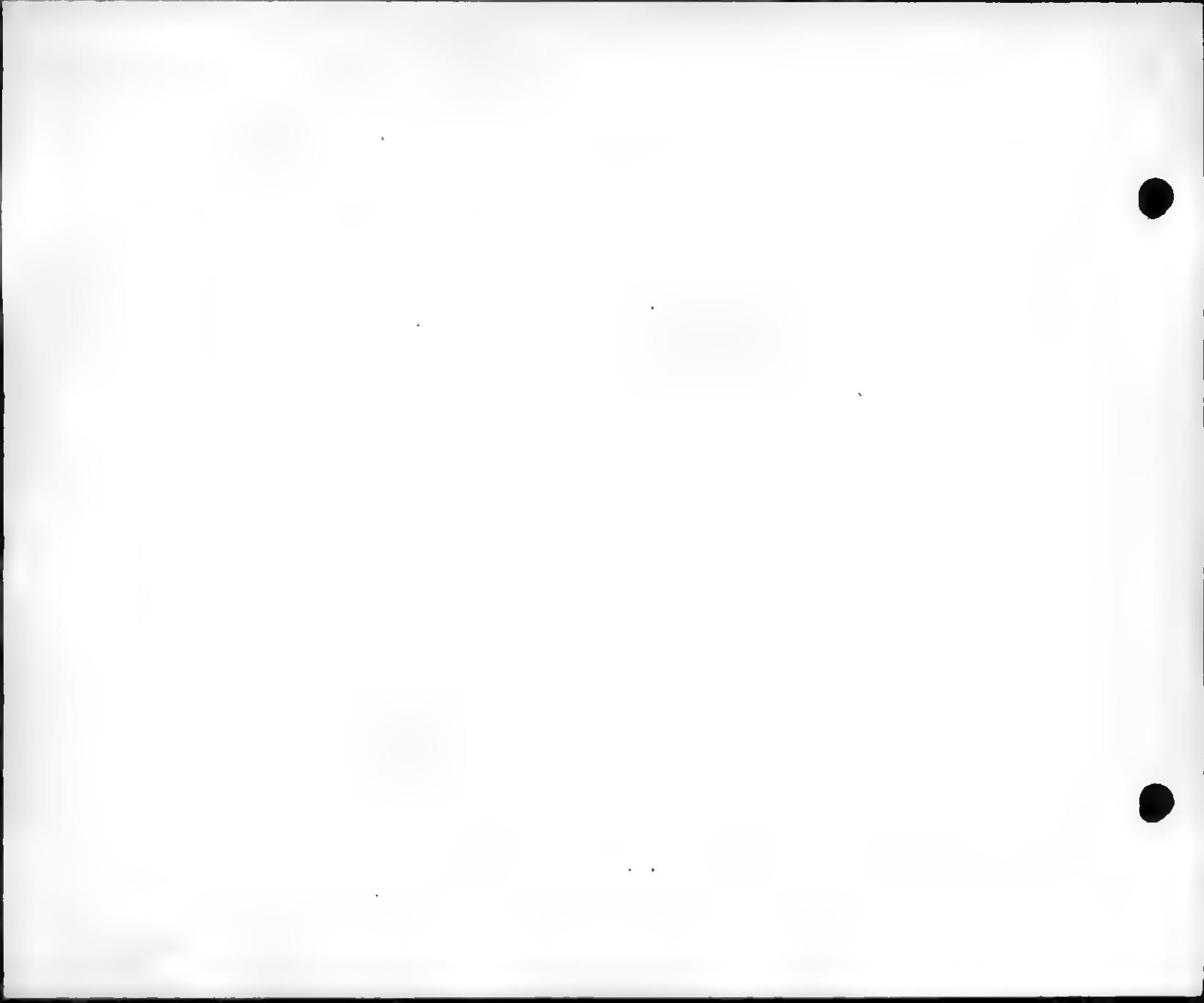
Items 18 & 21 10-17-66 ams MARYLAND STATE DEPARTMENT OF HEALTH  
Film 70 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M. *Prince George*

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH								11780		
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <b>Md.</b> Prince George						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b. <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>701 60th pl</b>						
3. NAME OF DECEASED (Type or print)		First <b>Theresa</b>	Middle <b></b>	4. DATE OF DEATH <b>Maynard</b>	Month <b>3</b>	Day <b>21</b>	Year <b>1966</b>			
S SEX <b>F</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED WIDDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 Sept. 1933</b>	9. AGE (In years last birthday) <b>32 yrs</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS Days <b></b>	Hours <b></b>	Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			Acute circulatory collapse and pulmonary edema Hemorrhage from incomplete abortion						INTERVAL BETWEEN ONSET AND DEATH 40 hrs.	
DUE TO (b) DUE TO (c)										
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED <b>3-12-66</b>
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe, M.D.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-21-66</b>		23b. DATE THEREOF <b>3-21-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery, Va</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va</b>				
24. FUNERAL DIRECTOR <b>W. H. Bacon 1722 7th St. N.W.</b>		ADDRESS <b>1722 7th St. N.W.</b>		25a. REC'D BY REGISTRAR <b>Charles J. Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>		DATE <b>AUG 19 1966</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

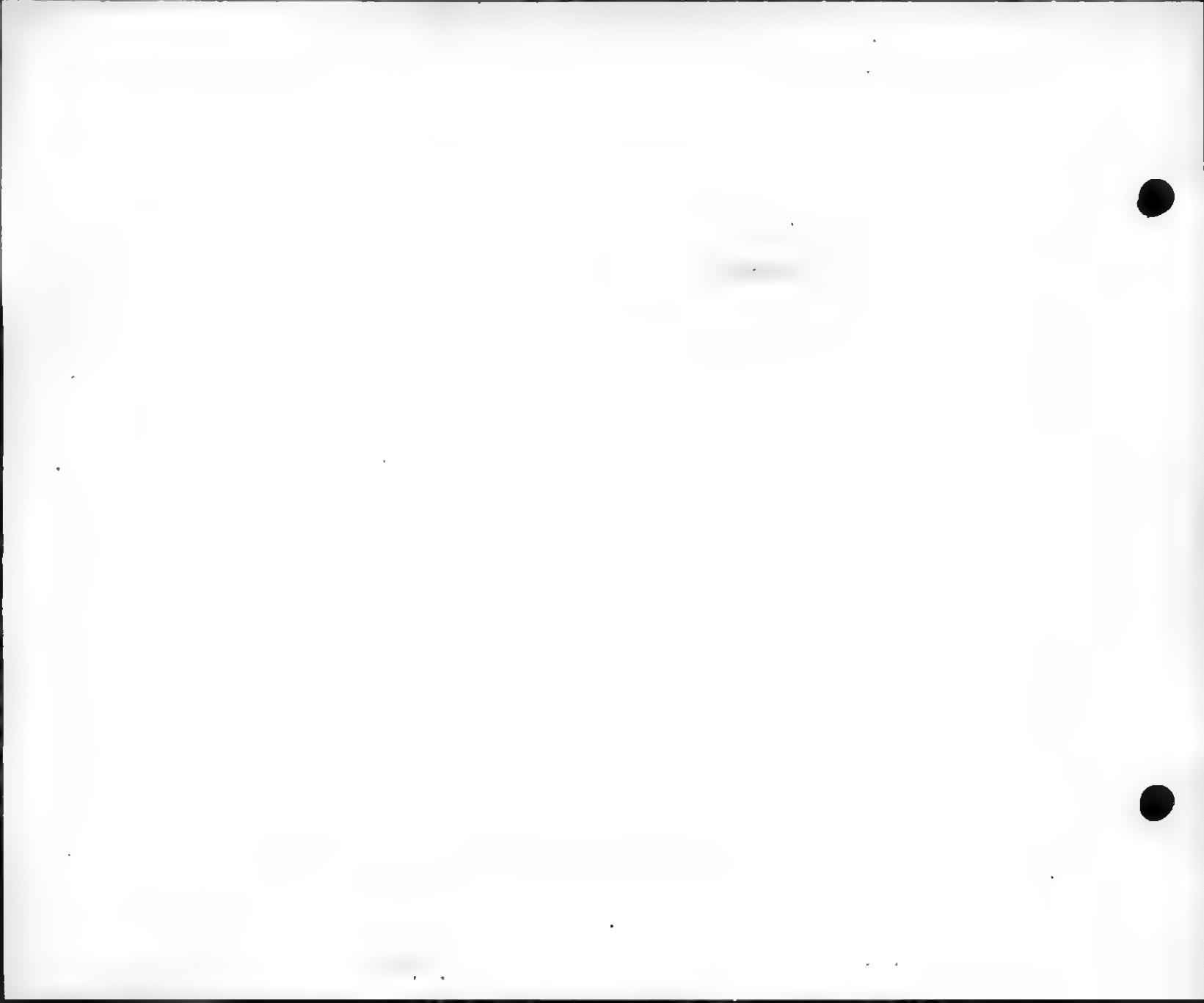
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if City delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PN3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

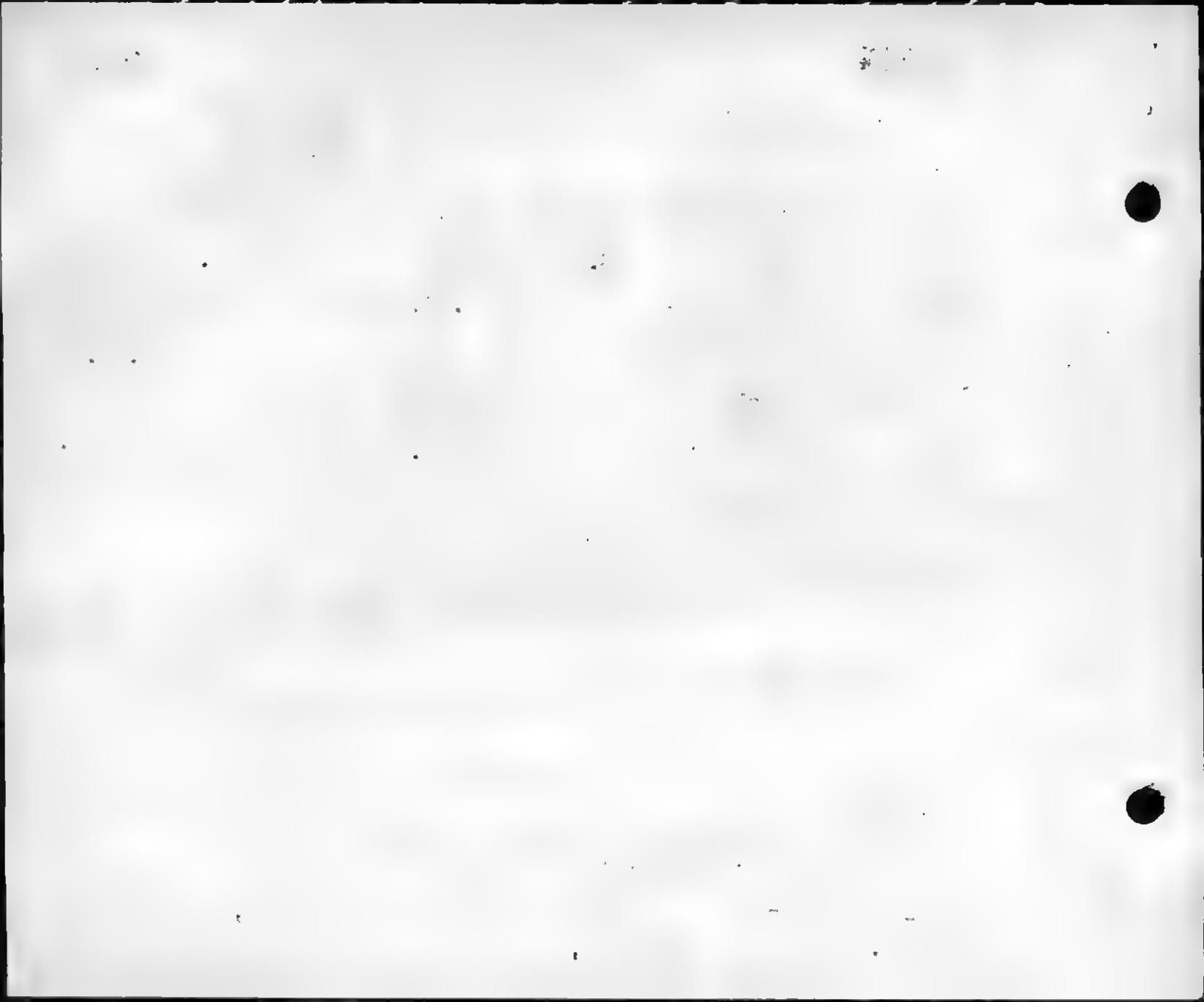
04246				04238	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's			
c. LENGTH OF STAY IN TB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moretown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 9375 Leona Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Caroline Gertrude Mc Covan		Fist	Middle	last	4. DATE OF DEATH 3 7 1966
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-14-38	9. AGE (In years at birthday) 77 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ontario, Canada	
13. FATHER'S NAME Edward McRiley Terryberry		14. MOTHER'S MAIDEN NAME Charlotte Jane Pugh		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO -----		17. INFORMANT Andrew B.I. McGowan Address 41081 Eastern Lane Suitland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure		INTERVAL BETWEEN ONSET AND DEATH minutes			
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease		Unknown			
DUE TO  (b) Arteriosclerotic Heart Disease					
DUE TO  (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED 3-1-66	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/10/66	23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery	23d. LOCATION (City or Town) Prince Georges County, Md.	(County) (State)
24. FUNERAL DIRECTOR The S.H. Hines Company		ADDRESS 2901 14th St. Washington, D.C.		25a. REC'D BY, REGISTRAR MAR 14 1966	25b. REGISTRAR'S SIGNATURE Charles J. Hines



HOSPITAL OR FEE: Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George County Hospital</b>												
3. NAME OF DECEASED (Type or print)			First <b>ANNE</b>	Middle <b>R.</b>	Last <b>McVEIGH</b>	4. DATE DEATH	Month <b>Mar.</b>	Day <b>9</b>	Year <b>19 66</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1892</b>	9. AGE (In years last birthday) <b>74 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>William Rusk</b>		14. MOTHER'S MAIDEN NAME <b>Serepta Beckwith</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>Son</b> <b>Donald R. McVeigh</b>	Address <b>Same as Item 2.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> too, DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury In Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>60</b> , to <b>March</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Mar 4</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			22a. SIGNATURE <b>Clifton R. Brooks</b>									
22c. PHYSICIAN'S NAME (Type) <b>Clifton R. Brooks, M.D.</b>			22b. DATE SIGNED <b>Richard '66</b>									
23a. BURIAL, CREMATION, REMDVAL (Specify) <b>Burial-transit</b>			23b. DATE THEREOF <b>3-10-66</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Greenwood Cemetery</b>			23d. LOCATION (City, town or county) <b>Wheeling, West Virginia</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>			ADDRESS <b>Bethesda, Maryland</b>			25a. REC'D BY REGISTRAR <b>DAR 14 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



M

04243

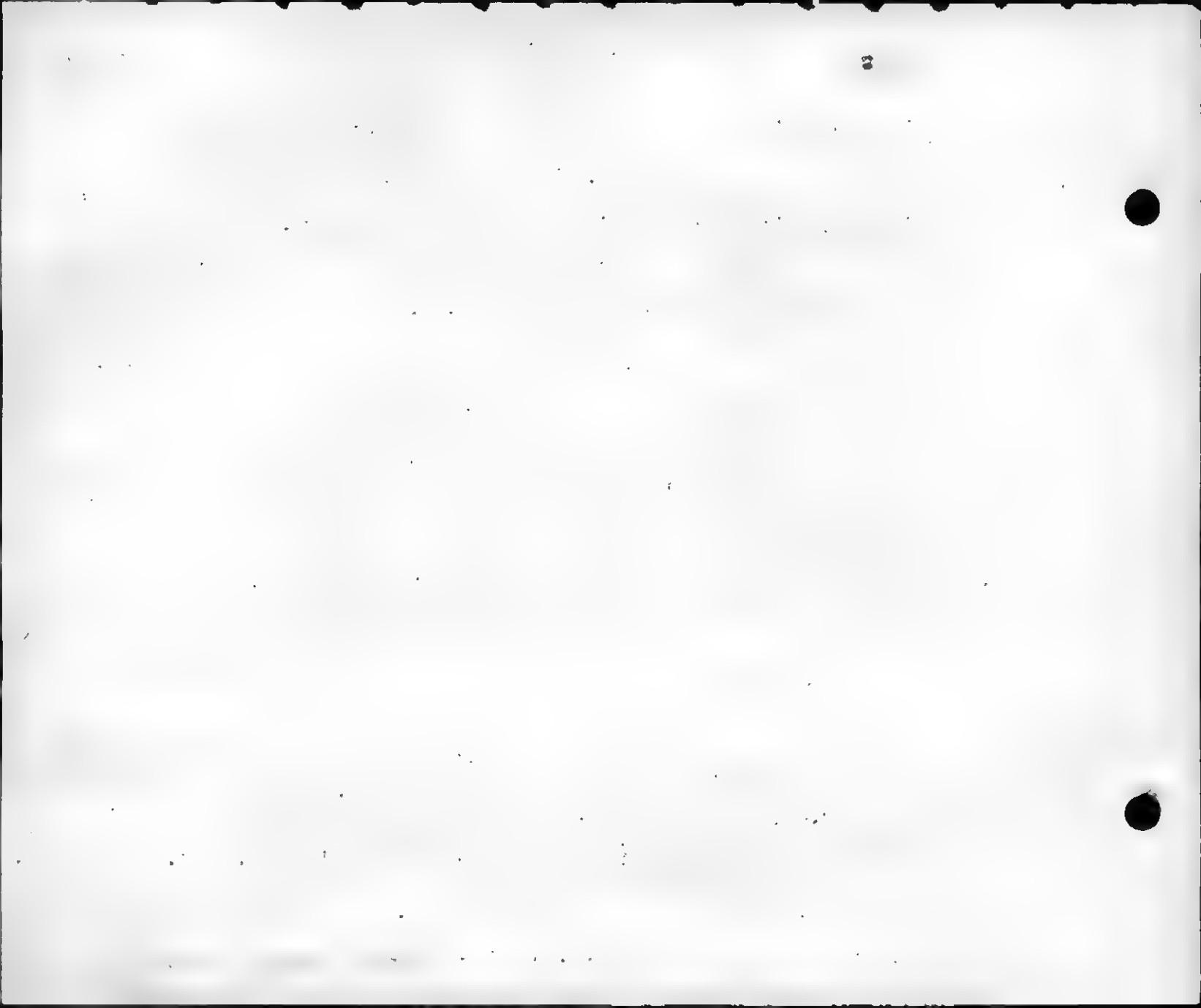
## CERTIFICATE OF DEATH

114241

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 mos. 19 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>Oxon Hill 432 Muary Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Mary</b>	Middle <b>Ann</b>
Last <b>Meredith</b>		4. DATE OF DEATH <b>March 31 1966</b>	Month Day Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Dec. 1, 1901</b>		9. AGE (in years (last birthday) <b>64 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Francis Berry</b>	14. MOTHER'S MAIDEN NAME <b>Mary Jane Johnson</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Rachel J. Belles 5961 23rd Pky. H.H.Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420/</b> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>Intraventricular Hypertension</b> (b) DUE TO <b>Subendocardial Infarction</b> and (c) DUE TO <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Injury in this case is not traumatic, it refers to cardiac condition-Ischemia injury or infarction.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>January 12 1966</b>		20d. INJURY OCCURRED <b>While at work</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Not While at work</b>
20f. (City or town) <b>Suitland</b>		(State) <b>Maryland</b>	
21. I certify that (X) this hospital attended the deceased from <b>January 12 1966</b> to <b>March 31, 1966</b> , that (X) we last saw the deceased alive on <b>March 31 1966</b> , and that death occurred at 1:15 P.M. from the causes and on the date stated above.		22b. DATE SIGNED <b>4/1/66</b>	
22a. SIGNATURE <b>Carolina Paredes Manlapaz M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>4/1/66</b>
22c. PHYSICIAN'S NAME (Type) <b>Carolina Paredes Manlapaz</b>		22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-4-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wash. National Cem.</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home 300 4th St. N.E. Wash. D.C.</b>		23d. LOCATION (City, town or county) <b>Suitland Maryland</b>	
		25a. REC'D BY REGISTRAR <b>APR 6 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04242

04243  
1. PLACE OF DEATH

2. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1B  
days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

T.U.M.H.

3. NAME OF  
DECEASED  
(Type or print)First  
CoraMiddle  
B.Last  
Miller

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

yrs.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (County &amp; State, or foreign country)

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME

Job Williams

14. MOTHER'S MAIDEN NAME

Caroline Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, No, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

No

Mrs. Alice Moon (above address)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

(Daughter)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

OUE TO

Conditions, If any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

OUE TO

(c)

INTERVAL BETWEEN  
DNSE AND DEATH

19 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 1920d. INJURY OCCURRED  
While at work  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 14, 1966, to Mar. 4, 1966, that (I) (we) last  
saw the deceased alive on Mar. 4, 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Charles C. Hageage  
22c. PHYSICIAN'S  
NAME (Type)

Charles C. Hageage, M.D.

M.O. ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.

March 5, 1966

22b. DATE SIGNED

3308 Perry St., Mt. Rainier, Md.

23a. BURIAL, CREMATIION,  
REMOVAL (Specify)

Burial

3/8/66

23b. DATE THEREOF

Fort Lincoln Cemetery

23d. LOCATION (CITY, TOWN OR COUNTY)

(STATE)

24. FUNERAL DIRECTOR

Nalley's

Funeral Home Inc.

ADDRESS

Mt. Rainier, Maryland

25a. REC'D BY REGISTRAR

MAR 9 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M

04250

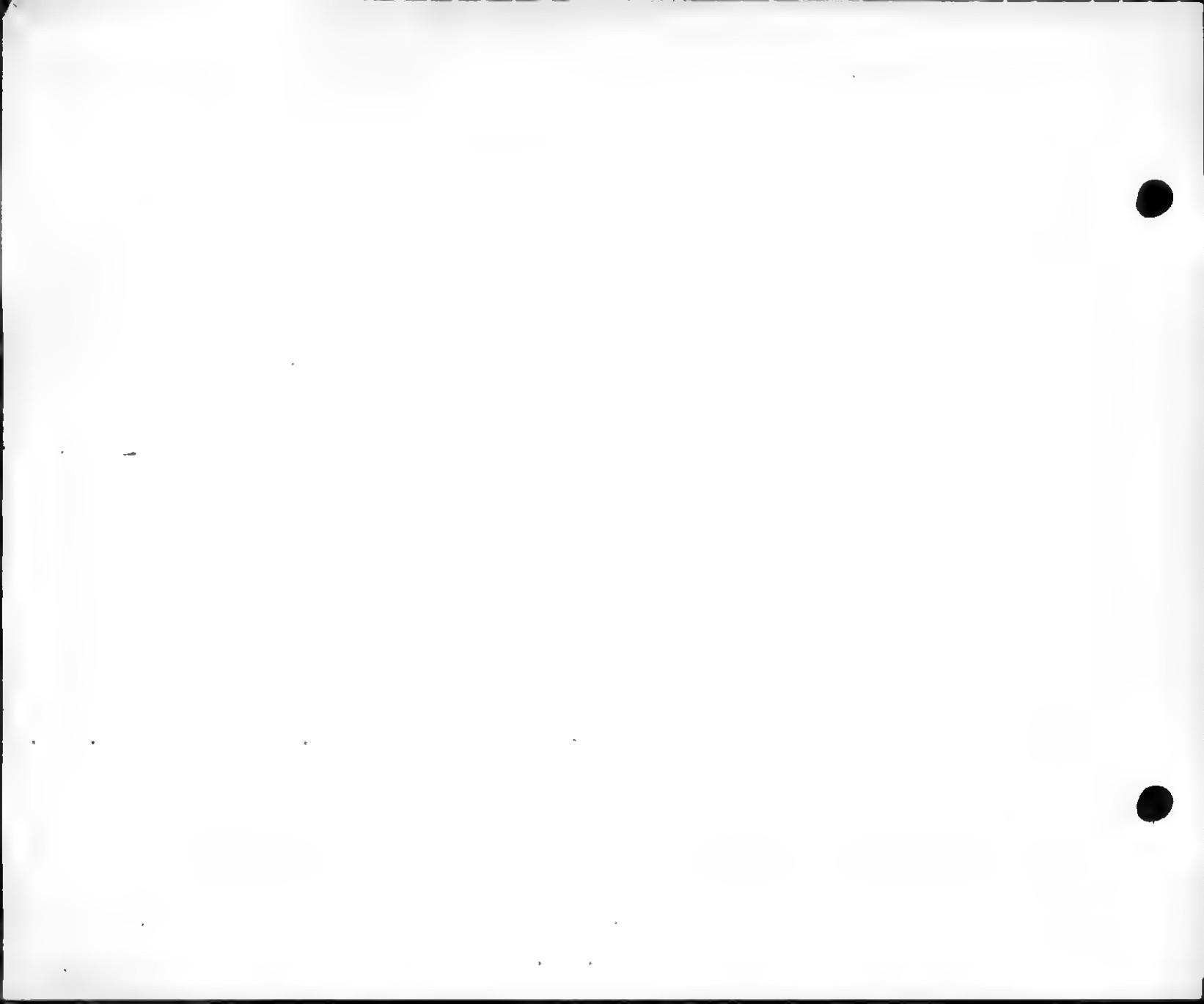
04243

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN MD seven days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston	
3 NAME OF DECEASED (Type or print) Robert		f. STREET ADDRESS 5203 Decatur St. Hyattsville, Md.	
4 DATE OF DEATH 3 26 1966	g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Month	Day Year
5 SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED	8 DATE OF BIRTH 11-3-29
9 AGE (In years last birthday) 36 yrs.	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	10b KIND OF BUSINESS OR INDUSTRY Building	11 BIRTHPLACE (State or foreign country) Pro Geo Co Md.
12 CITIZEN OF WHAT COUNTRY? USA	13 FATHER'S NAME James C. Miller		
14 MOTHER'S Maiden Name Julia Mc Kenney		15 INFORMANT Catherine M Smith Hollywood Florida	
16 SOCIAL SECURITY NO 215 26 3035		17 Address	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 8124 Left Subdural Hematoma		INTERVAL BETWEEN ONSET AND DEATH	
Cond. tions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Multiple Skull Fractures (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) pedestrian struck by car	
20c TIME OF INJURY Month, Day, Year Hour a.m. 1:45pm pm 3-19- 1966		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Kenilworth Decatur St. Hyattsville, P.G., Md.
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe L.P., Riverdale, Maryland	
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF Mar 30, 1966	23c NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a REC'D BY REGISTRAR Colmar
			25b REGISTRAR'S SIGNATURE MAR 29 1966 gCharles Judge

VR A15ME (5)  
6M 1/66



1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND b. COUNTY PRINCE GEORGE'S</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANHAM.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>				
c. LENGTH OF STAY IN 1b <b>1 week</b>		d. STREET ADDRESS <b>12231 SHAFER LANE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MAGNOLIA GARDEN'S</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ETHEL</b>	Middle <b>M</b>	Last <b>MIRE</b>			
4. DATE OF DEATH <b>3 8 1966</b>	Month Year	Day	Year			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-94</b>			
9. AGE (In years last birthday) <b>71 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant Owner</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Self Restaurant</b>	12. CITIZEN OF WHAT COUNTRY? <b>Richmond - Virginia</b>			
13. FATHER'S NAME <b>?</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ruby E. Peache Same as #2 (daughter)</b>	Address <b>Carey &amp; Henrichs</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hyper Tension</b> DUE TO (b) DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 years</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Colmar Manor</b>	(County) <b>Md.</b>	(State) <b>Colmar Manor, Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>7-3-1966</b> , to <b>7-8-1966</b> , that (I) (we) last saw the deceased alive on <b>7-7-1966</b> , and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.				22b. DATE SIGNED <b>3-8-66</b>		
22a. SIGNATURE <b>Louis M. Jimal</b>		22c. PHYSICIAN'S NAME (Type) <b>Louis M. Jimal</b>		22d. ADDRESS <b>5705 Lamont St., Hyattsville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/11/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>	23d. LOCATION (City, town or county) <b>Colmar Manor,</b>	(State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 11, 12, 13, 14, 15, G-75, 1/2/66

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

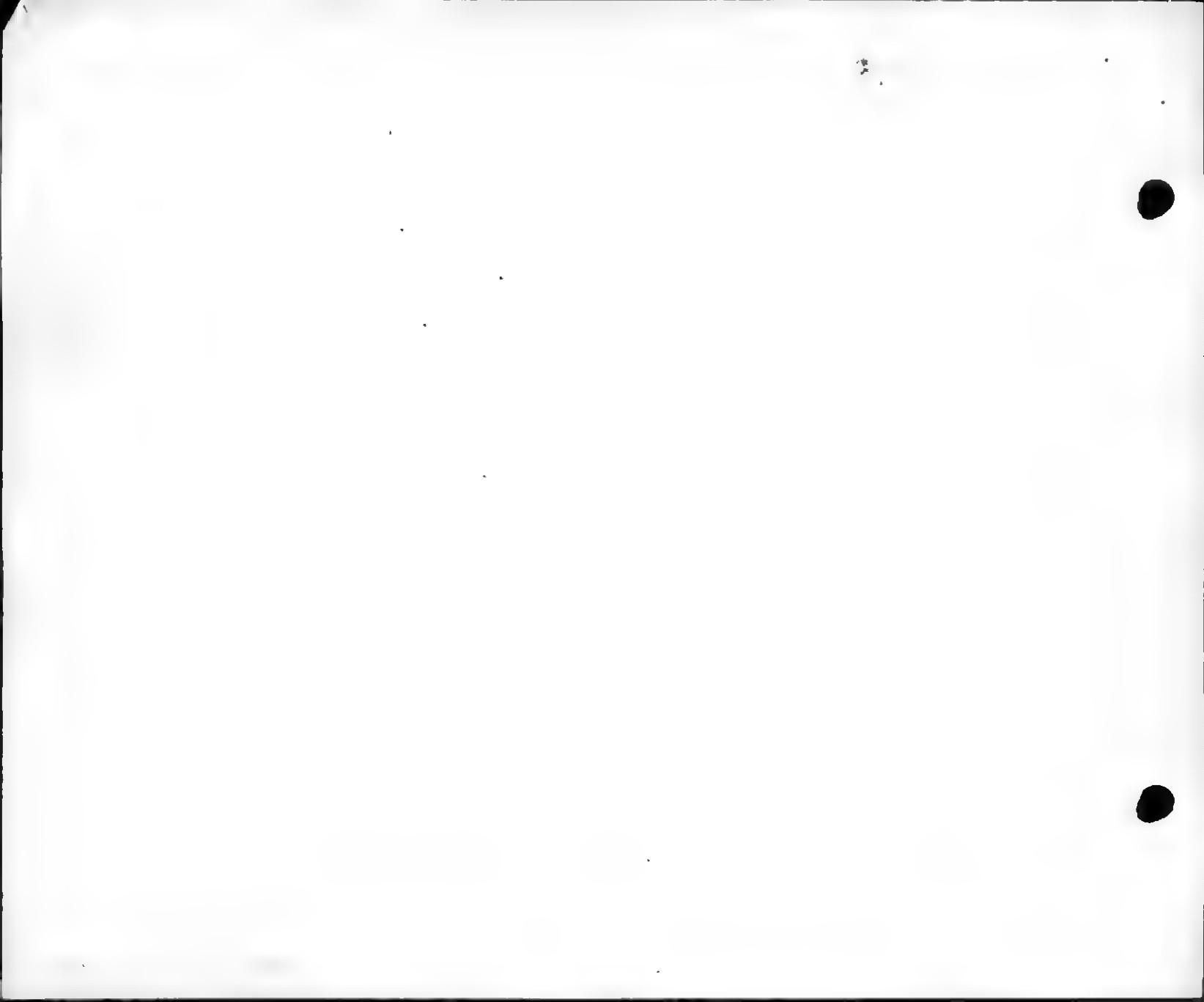
04245 ✓

FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit file pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>N.C.</b>		b. COUNTY <b>Halifax</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George Gen ral Hospital</b>				d. STREET ADDRESS <b>Rt. 2, Box 137</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Thomas</b>		First	Middle	Last	4. DATE OF DEATH <b>Mitchell</b>	Month <b>3</b>	Day <b>19</b>	Year <b>1966</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH <b>8 Aug., 1919</b>	9. AGE (In years last birthday) <b>46 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Scotsburgh, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Tom Mitchell</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Mitchell</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b>						INTERVAL BETWEEN ONSET AND DEATH Minutes				
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. <b>+201</b>		(b) <b>Myocardial infarction</b>					days			
(c) <b>Occlusion of coronary artery</b>										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Kehoe</i> John Kehoe, M.D., Riverdale						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						Address (Street, city, town, or county) <b>3894 1/2 Riverdale</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Mar 20, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Scotsburgh Cemetery</b>		23d. LOCATION (City or Town) <b>Scotsburgh Halifax Va</b>		(County) (State)		
24. FUNERAL DIRECTOR <b>Frazee Funeral Home Inc.</b>		ADDRESS <b>3894 1/2 Riverdale</b>				25a. REC'D BY REGISTRAR <b>MAR 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

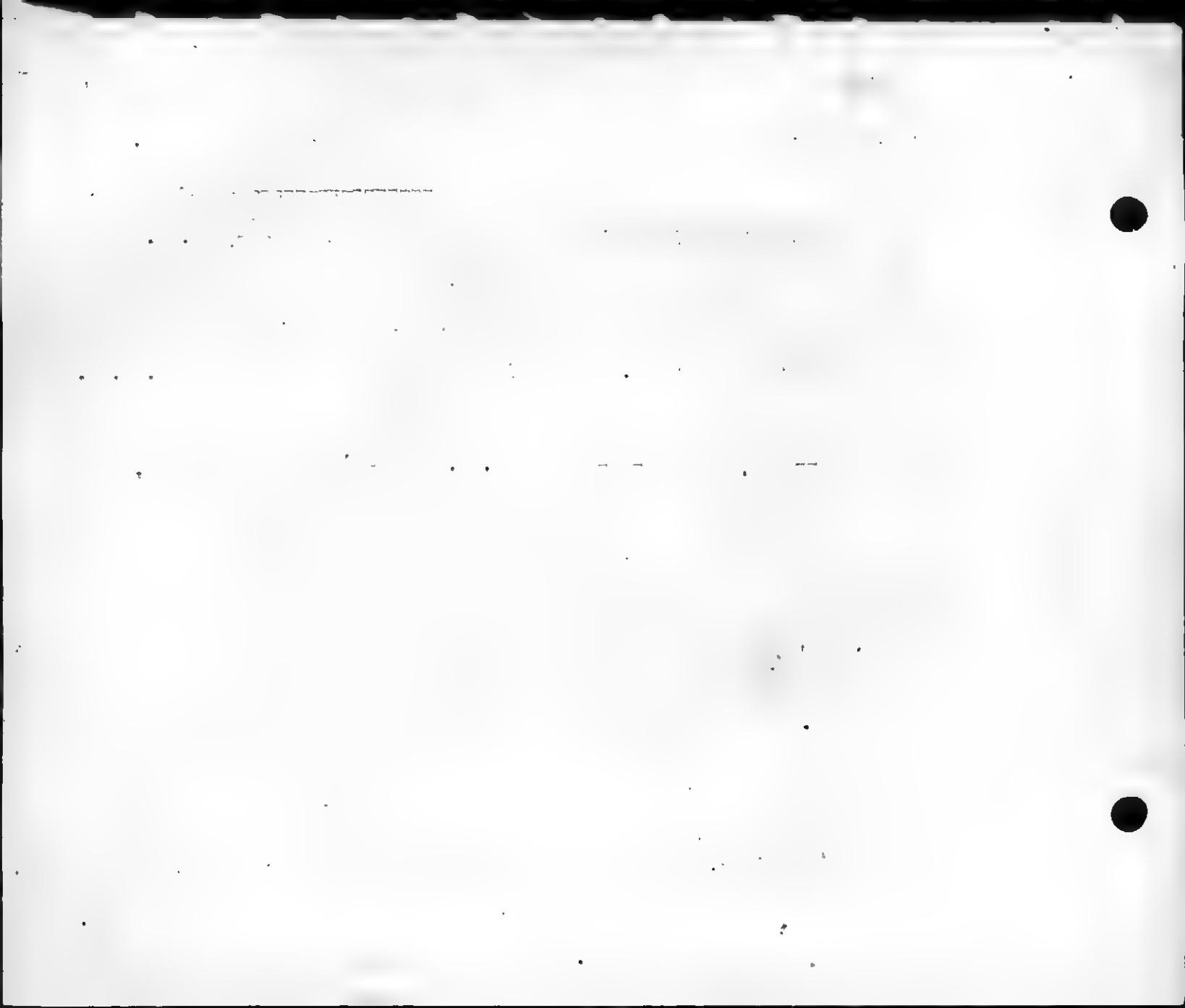


**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>12 days</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>									b. COUNTY <b>Pr. Geo's</b>		
3. NAME OF DECEASED (Type or print) <b>Floyd</b>			First	Middle	Last	4. DATE OF DEATH Month <b>March</b>			Day	Year	
5. SEX <b>Male</b>			6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1900</b>	9. AGE (in years last birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <b>Employd Carpenter's Helper Gen. Construction</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>224-07-9863</b>			17. INFORMANT <b>W. C. Duley-</b>			Address <b>Box 3300 Upper Marlboro, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH		
Coronary Artery Disease											
(c) <b>Pneumonia</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>pneumonia</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>March 19, 1966</b> , to <b>March 31, 1966</b> , that (we) last saw the deceased alive on <b>March 31, 1966</b> , and that death occurred <b>11:55</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Edwin J. Jensen</b>									22b. DATE SIGNED <b>April 1, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>			22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/4/66</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Washington National Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Suitland Md.</b>		
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>APR 13 1966</b>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

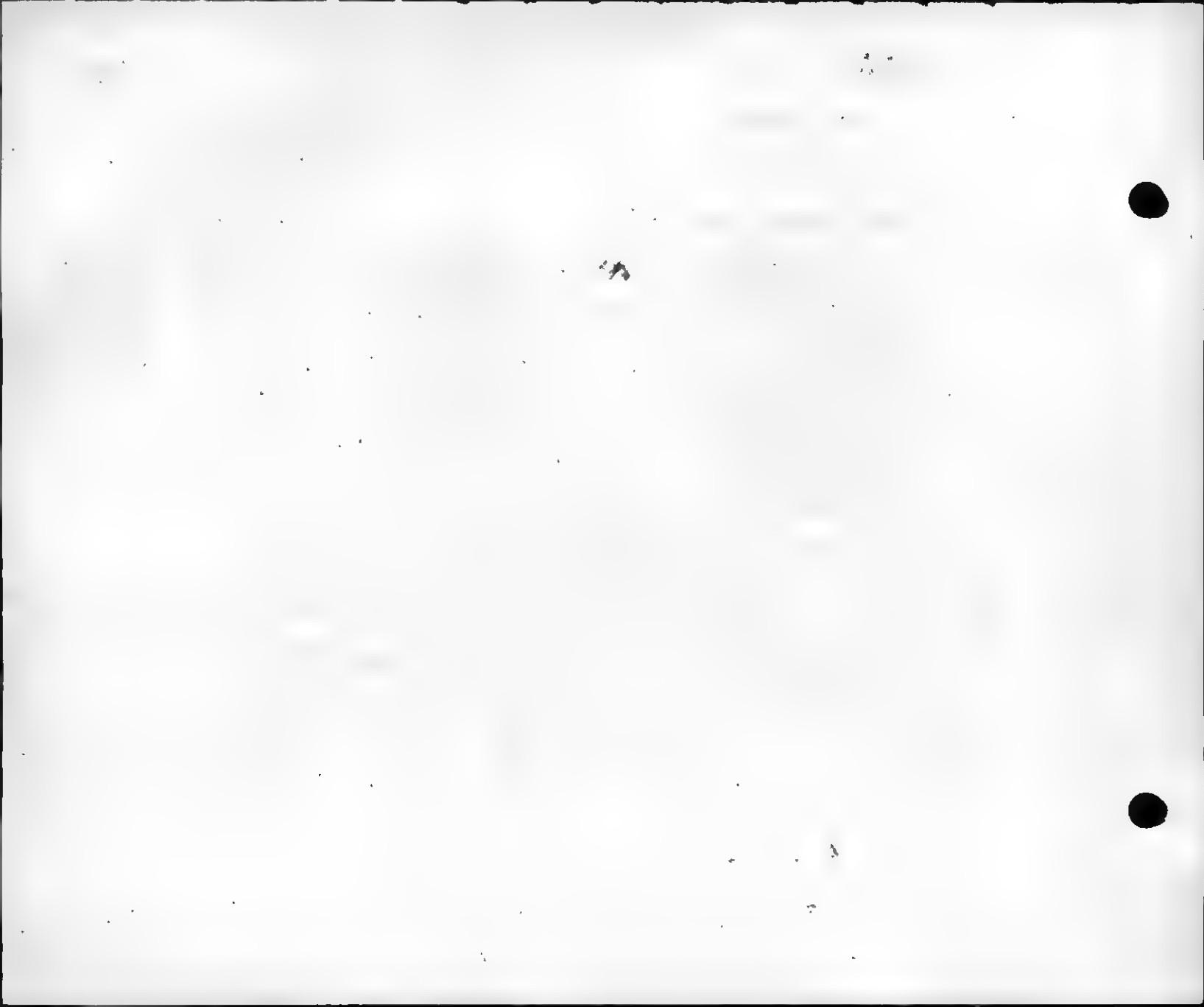
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04254

## CERTIFICATE OF DEATH

04246

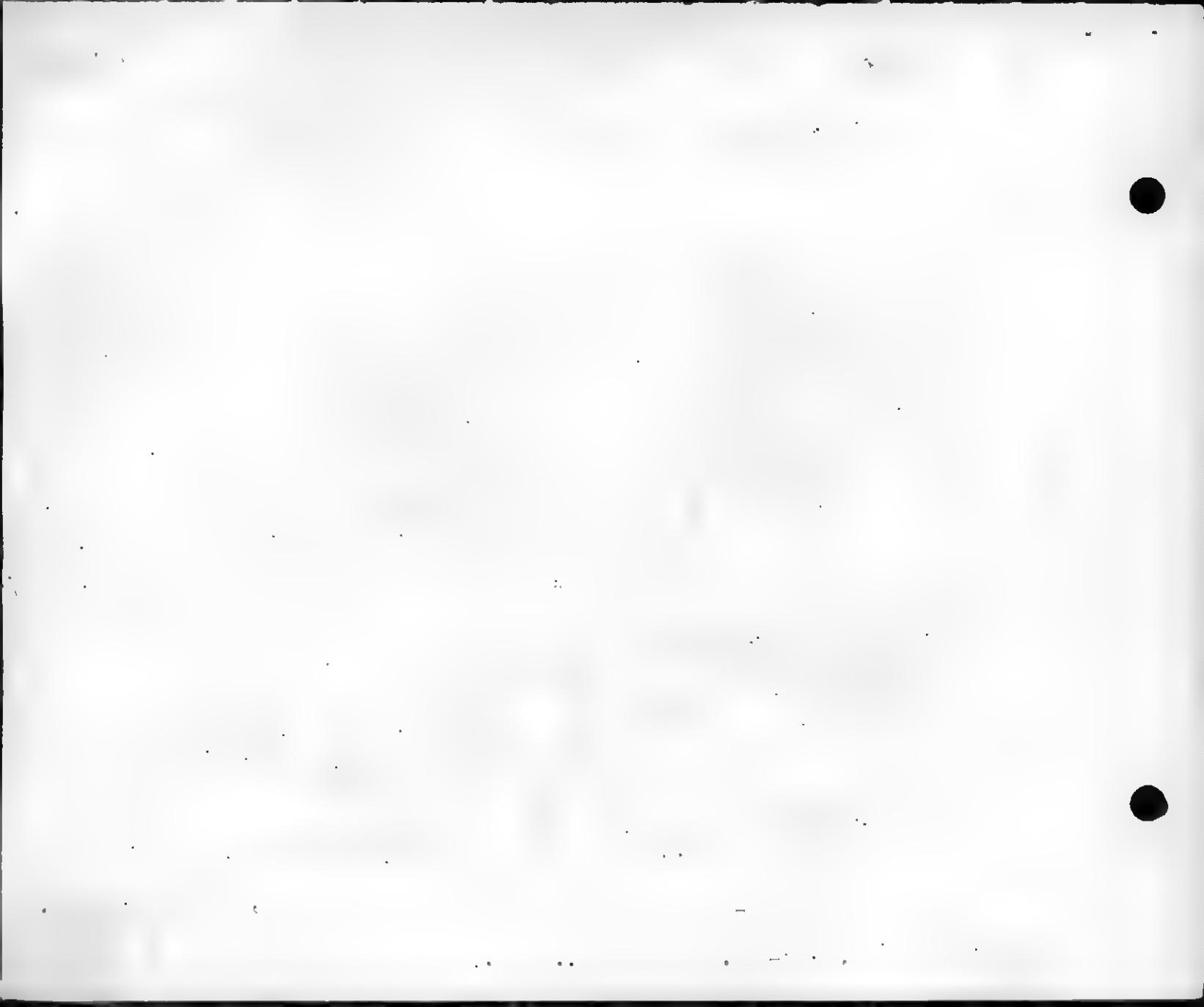
1. PLACE OF DEATH 8. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Frank</b>	Middle <b>PARRY</b>	Last <b>Moore</b>
4. DATE OF DEATH Month <b>March</b>	Month <b>6</b>	Day <b>1966</b>	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Mar., 1910</b>
9. AGE (In years last birthday) <b>55 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. TRANSIT CO</b>	11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	13. FATHER'S NAME <b>FRANK P. MOORE</b>		
14. MOTHER'S MAIDEN NAME <b>OLA POLLARD</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>578 10 6076</b>		17. INFORMANT <b>FRANCES A. MOORE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b>		Address <b>SAME AS #2</b>	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of Liver</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hyattsville, Maryland</b>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>225</b> , 19 <b>66</b> , to <b>3-6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-5</b> 19 <b>66</b> , and that death occurred at <b>5.00 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Aaron Dritz</b>		22b. DATE SIGNED <b>3-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>AARON DRITZ</b>		22d. ADDRESS <b>HYATTSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9 MAR 1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>F. LINCOLN CEM</b>		23d. LOCATION (City, town or county) (State) <b>BLADENSBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>I.W. Chambers Co Riverdale, Md</b>		25a. ADDRESS <b>ADDRESS</b>	
25b. REG'D BY REGISTRAR <b>REC'D BY REGISTRAR</b>		25d. REGISTRAR'S SIGNATURE <b>DATE</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)															
a. COUNTY <b>PRINCE GEORGES</b>				a. STATE <b>MARYLAND</b>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>				c. LENGTH OF STAY IN 1b <b>3 WKS</b>				b. COUNTY <b>PRINCE GEORGES</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SO. MD. HOSP. CENTER</b>				d. STREET ADDRESS <b>99 BRANDYWINE 16.</b>															
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)			First <b>EDWARD</b>	Middle <b>FRANKLIN</b>	Last <b>MORSE</b>	4. DATE OF DEATH Month <b>3</b>	Month <b>1</b>	Day <b>19</b>	Year <b>66</b>										
5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-79</b>	9. AGE (In years last birthday) <b>87 yrs.</b>	IF UNDER 1 YEAR Months <b>87</b>		IF UNDER 24 HRS. Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEWSPAPER DISTRIBUTOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NEWSPAPER</b>			11. BIRTHPLACE (County & State, or foreign country) <b>CARTER CO. N.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>										
13. FATHER'S NAME <b>EDWARD S. MORSE</b>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>LOUISE M. HIGGINS - 99 BRANDYWINE HWS</b>				Address <b>BRANDYWINE</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE FAILURE</b> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED CIRCUMDATOSA'S</b> DUE TO (c) <b>CARCINOMA OF HEAD OF PANCREAS</b>																			
INTERVAL BETWEEN ONSET AND DEATH <b>3 HRS.</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC PYELONEPHRITIS WITH UREMIA, MILD</b>																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
MEDICAL CERTIFICATION			20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>None</b>			20d. INJURY OCCURRED WHEN AT WORK <b>NOT WORKING</b>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>			20f. (City or town) (County) (State) <b>None</b>	
21. I certify that (I) (This hospital) attended the deceased from <b>SEPT 1961</b> to <b>PRESENT</b> , that (I) (we) last saw the deceased alive on <b>MAR 1 1966</b> and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Arthur Shaver Jr.</b>																			
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22d. DATE SIGNED <b>3/1/66</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>March 3-1966</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>			23d. LOCATION (City, town or county) <b>Suitland, Maryland.</b>			(State)							
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>			ADDRESS <b>Simmons Bros. 1661- Gd. Hope Road SE. Wash.DC</b>			25a. REC'D BY REGISTRAR <b>MAR 3 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>										
VR A15 (4) 20M 1/65																			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be retained by the hospital or attending physician.

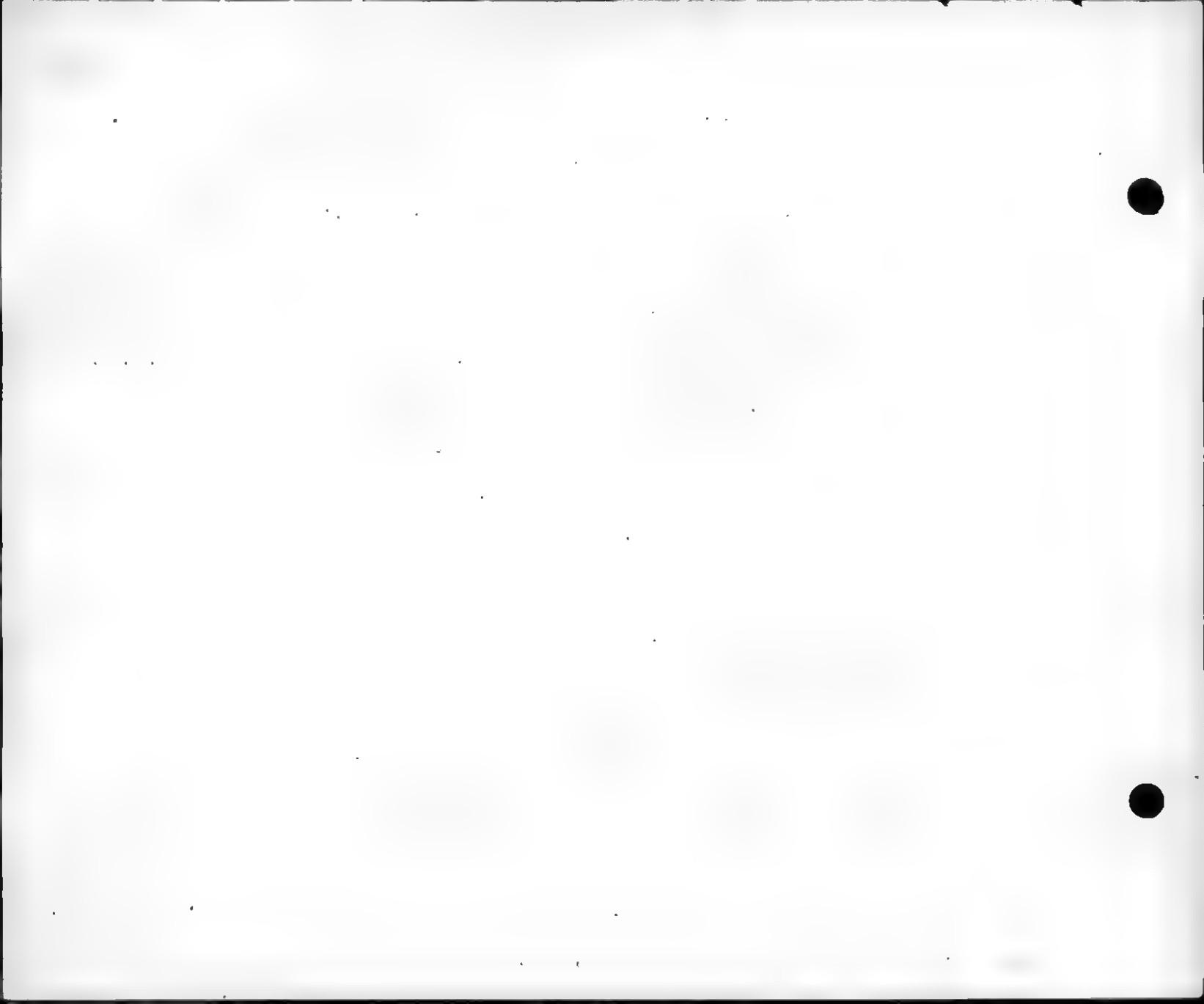
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>		c. LENGTH OF STAY IN 1b <b>2 MONTHS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>EUGENE LELAND MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLLEGE PARK</b>	
3. NAME OF DECEASED (Type or print) <b>BENJAMIN</b>		First <b>BENJAMIN</b>	Middle <b>MOSKOWITZ</b>
4. DATE OF DEATH <b>MARCH 2 1966</b>		Last <b>MOSCOWITZ</b>	Month Day Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASION</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>5-15-1890</b>		9. AGE (in years last birthday) <b>75 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Romania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Moskowitz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
17. INFORMANT <b>Unknown</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>			
42 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>ATRIAL FIBRILLATION</b>			
(c) <b>GEN. ARTERIOSCLEROSIS</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS G-1 BLEEDING</b>			
19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Colmar Manor, Md.</b>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 1962</b> to <b>2 MARCH 1966</b> , that (I) (we) last saw the deceased alive on <b>1 MARCH 1966</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C. J. Horneau</b>		22b. DATE SIGNED <b>2 MARCH 1966</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3/3/66</b>	23c. NAME OF CEMETERY OR CEMETORY <b>Ft. Lincoln</b>
23d. LOCATION (City, town or county) <b>Colmar Manor, Md.</b>		(State)	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
ADDRESS		DATE	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04257

## CERTIFICATE OF DEATH

04249

**TO HOSPITAL** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

## 1. PLACE OF DEATH

a. COUNTY

PRINCE GEORGE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

7 YRS.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

CARROLL MANOR 4922 LASALLE RD.  
HYTTS RD.3. NAME OF  
DECEASED  
(Type or print)

First CECILIA C.

Middle MUNTZ

4. SEX

F

6. COLOR OR RACE

W

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Gov Clerk.

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Gov.

11. BIRTHPLACE (County &amp; State, or foreign country)

GEORGE TOWN

13. FATHER'S NAME

THOMAS MUNTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

NOV

SR. Agnes

4922 LASALLE RD.

HYTTS RD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

492X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last. } (b)

{ (c)

DUE TO

Pneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Cerebral Thrombosis

Generalized Arteriosclerosis

Left hemiplegia

Hypertension

Heart Disease

20a. ACCIDENT WAS UNDERLYING ( ) OR CONTRIBUTING ( ) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from ... August 10, 1966 to March 24, 1966 that (I) (we) last

saw the deceased alive on March 23, 1966, and that death occurred at 4:15 PM from the causes and on the date stated above.

22a. SIGNATURE

Bertram F. Schaefer

22c. PHYSICIAN'S NAME (Type)

BERTRAM F. SCHAEFER MD

1780 Mass. Ave. N.W. Wash. D.C.

REMOVAL (Specify)

Burial

3-28-66

23a. BURIAL, CREMATION

23b. DATE THEREOF

REMOVED

24. FUNERAL DIRECTOR'S SIGNATURE

James E. DeVol DEVol FUNERAL HOME, WASH. D.C.

APRIL 1, 1966

MAR 31 1966

Charles Judge

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Holy Cross CEM.

23d. LOCATION (City, town or county)

WASHINGTON, D.C.

(State)

25a. REC'D BY REGISTRAR

MAR 31 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

26. IS RESIDENCE ON A FARM?

YES  NO 

Year

Hours Min.

Months Days

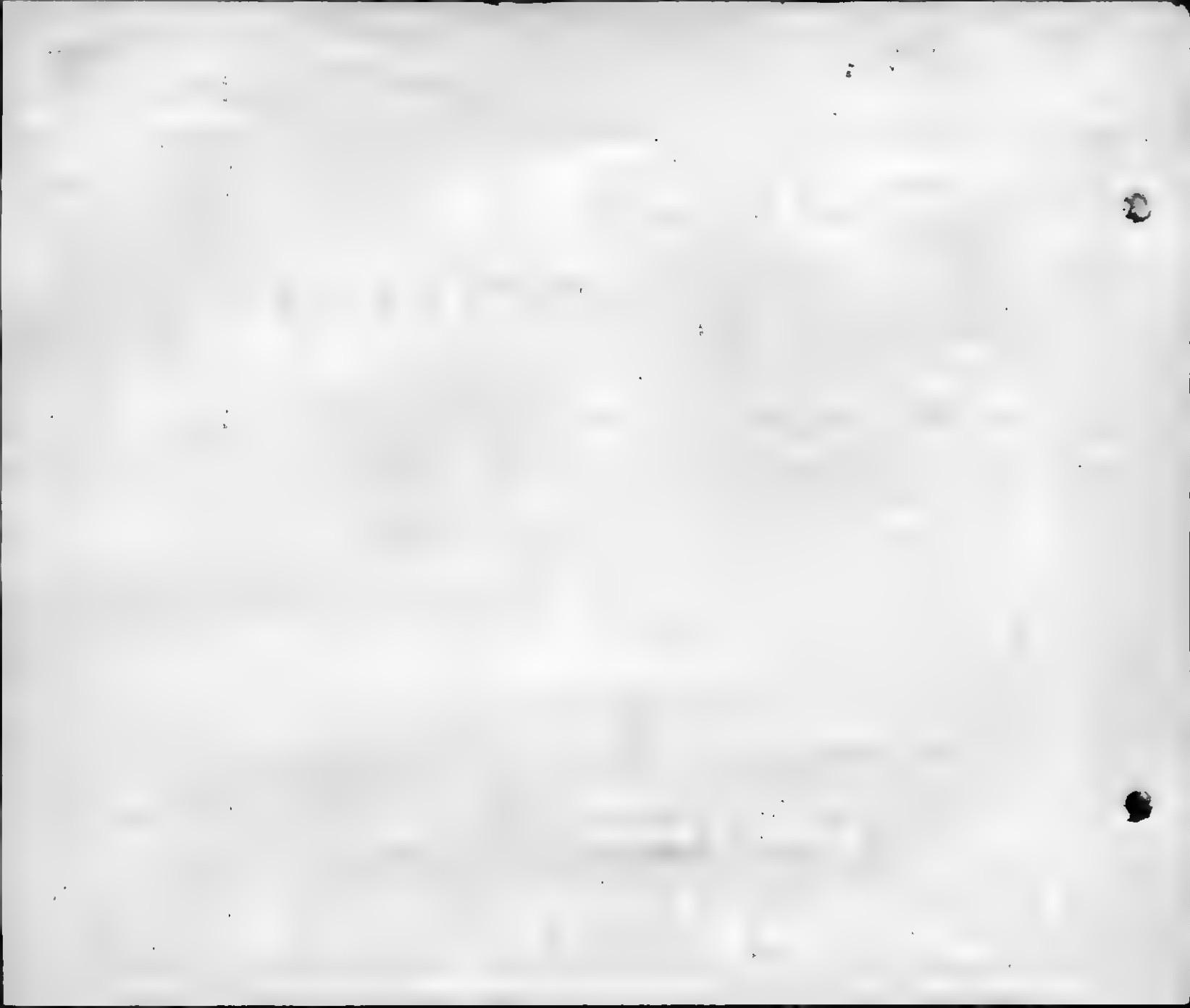
IF UNDER 24 HRS.

IF UNDER 1 YEAR

89 yrs.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.



**HOSPITAL OR ATTENDING PHYSICIAN:** This form requires that the death certificate be executed within 24 hours after death.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
Item 7 - Item 694 8/27/66 114250															
1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly													
c. LENGTH OF STAY IN 1b															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Prince George's General Hospital													
3. NAME OF DECEASED (Type or print)		First Ethel		Middle Louise		Last Myers		4. DATE OF DEATH		Month March Day 12 Year 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		WIDOWED		DIVORCED		3-26-1904		61 yrs.		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
House Wife				Wash., D.C.		U. S. A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
Lawrence Payne		Sheridan													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
(If yes give war or dates of service)		578 20 6875		John Henry Myers		Same as # 2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure															
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic coma															
(c) Carcinoma of the liver															
INTERVAL BETWEEN ONSET AND DEATH minutes															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Secondary metastasis															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
19															
21. I certify that (I) (this hospital) attended the deceased from June 1963 to March 1966, that (I) (we) last saw the deceased alive on May 5, 1966, and that death occurred at 3:00 P.M. from the causes and on the date stated above.															
22a. SIGNATURE															
22b. DATE SIGNED 3/12/66															
22c. PHYSICIAN'S NAME (Type)		David Anderson, M.D.													
23a. BURIAL, Cremation, Removal (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)							
Burial		3/14/1966		Arlington National Cemetery		Fort Myer, Va.									
24. FUNERAL DIRECTOR		ADDRESS													
Hartingsly		131-11th St. N.W. D.C.													
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
MAR 15 1966		Charles Judge													



M

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

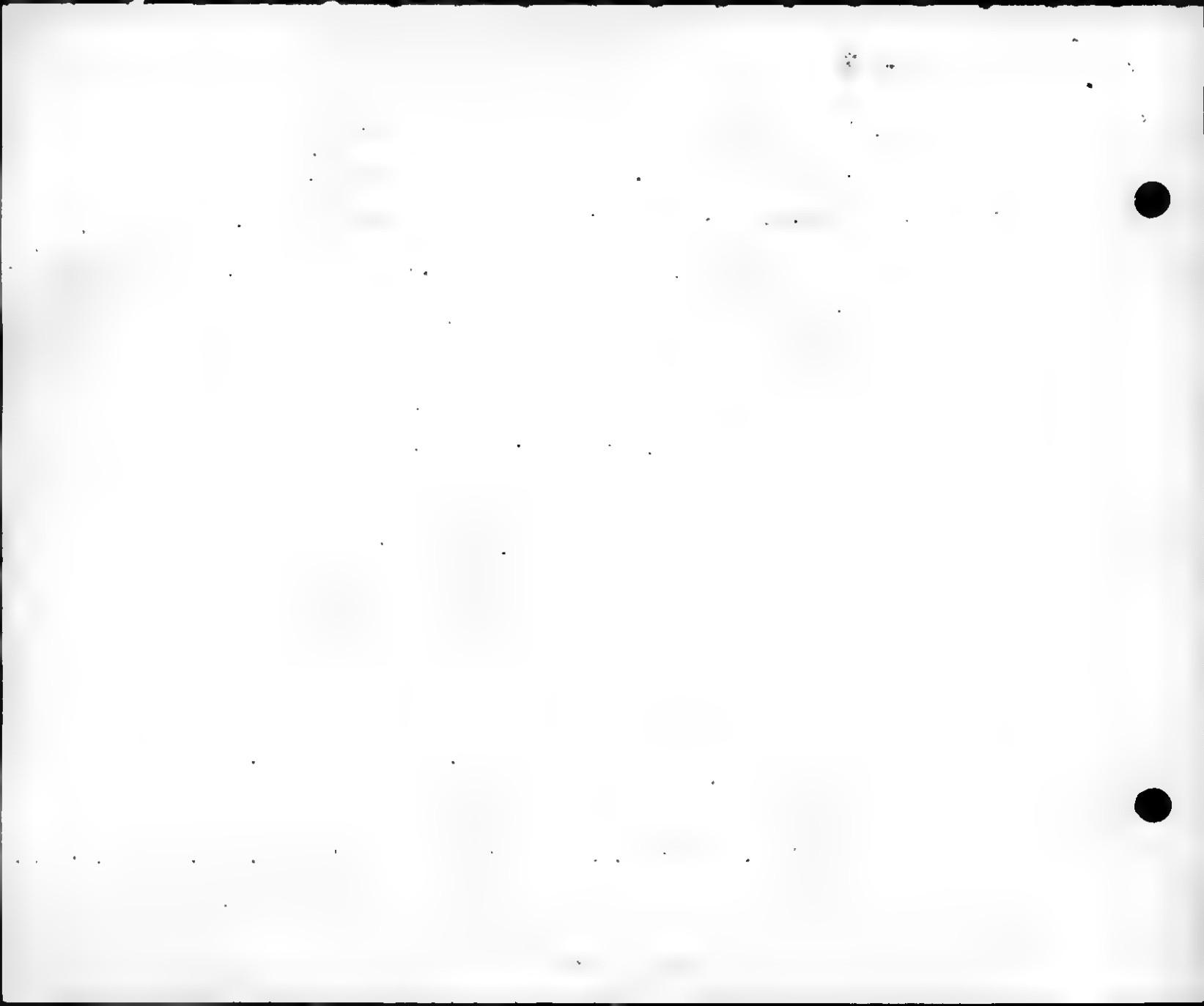
02253

114252

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Prince Georges MARYLAND		Maryland Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cheverly 14 hrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
Prince Georges General Hospital		Accokeek	
3. NAME OF DECEASED (Type or print)		First	Middle
Everett SAMUEL			PICKERAL
4. DATE OF DEATH		Month	Day Year
March 8 1966			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male White		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
JANITOR		WALDORF School	
11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
unk		unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
(If yes give war or dates of service)		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  301X		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		 Cerebrovascular Accident	
(b) DUE TO		Hypertension-vascular disease.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (X) this hospital attended the deceased from J Mar. 7, 1966, to Mar. 8, 1966, that (X) we last saw the deceased alive on Mar. 8, 1966, and that death occurred at 7:35 AM from the causes and on the date stated above.			
22a. SIGNATURE  Edwin J. Jeasen		22b. DATE SIGNED 8 March 66	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jeasen, M.D.		22d. ADDRESS Prince George's Genl. Hosp. Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-10-66	
23c. NAME OF CEMETERY OR CREMATORIUM CHRIST CHURCH		23d. LOCATION (City, town or county) ACCOKEEK, Md	
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD		ADDRESS	
		25a. REC'D. BY REGISTRAR MAR 11 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**UNIDENTIFIED OR ATTENDING PHYSICIAN.** The law requires that the death certificate be executed within 24 hours after death.

**NO HOSPITAL OR ATTENDING PHYSICIAN** is required under the new regulations that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## **CERTIFICATE OF DEATH**

04253

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 hr. 57 min.</b>		a. STATE <b>Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				b. COUNTY <b>Prince George's</b>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL</b>		First	Middle	Last	4. DATE OF DEATH <b>March 16 1966</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <b>XX</b>	8. DATE OF BIRTH <b>May 11, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <b>85 yrs.</b>	
13. FATHER'S NAME <b>Paul Polivanov</b>		14. MOTHER'S MAIDEN NAME <b>unobtaihable</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>101-26-2814</b>		17. INFORMANT <b>Sergey Polivanov 6304 47th Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.  DUE TO (b) <i>Pulmonary emphysema</i> Known for years  DUE TO (c) <i>Pulmonary interstitial fibrosis</i> Known for years				Address <b>Riverdale, Md</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <b>Known for years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Riverdale</b> (County) <b>Maryland</b> (State) <b>Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 12, 1965</b> , to <b>March 16, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 12, 1966</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Aaron H. Traum</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 17 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aaron H. Traum, M.D.</b>		22d. ADDRESS <b>8237 Georgia Ave. Silver Spring Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/19/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Rock Creek Cemetery</b>	
24. FUNERAL DIRECTOR <b>The S. H. Hines Co.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
				25b. REGISTRAR'S SIGNATURE <b>DATE MAR 21 1966</b>	

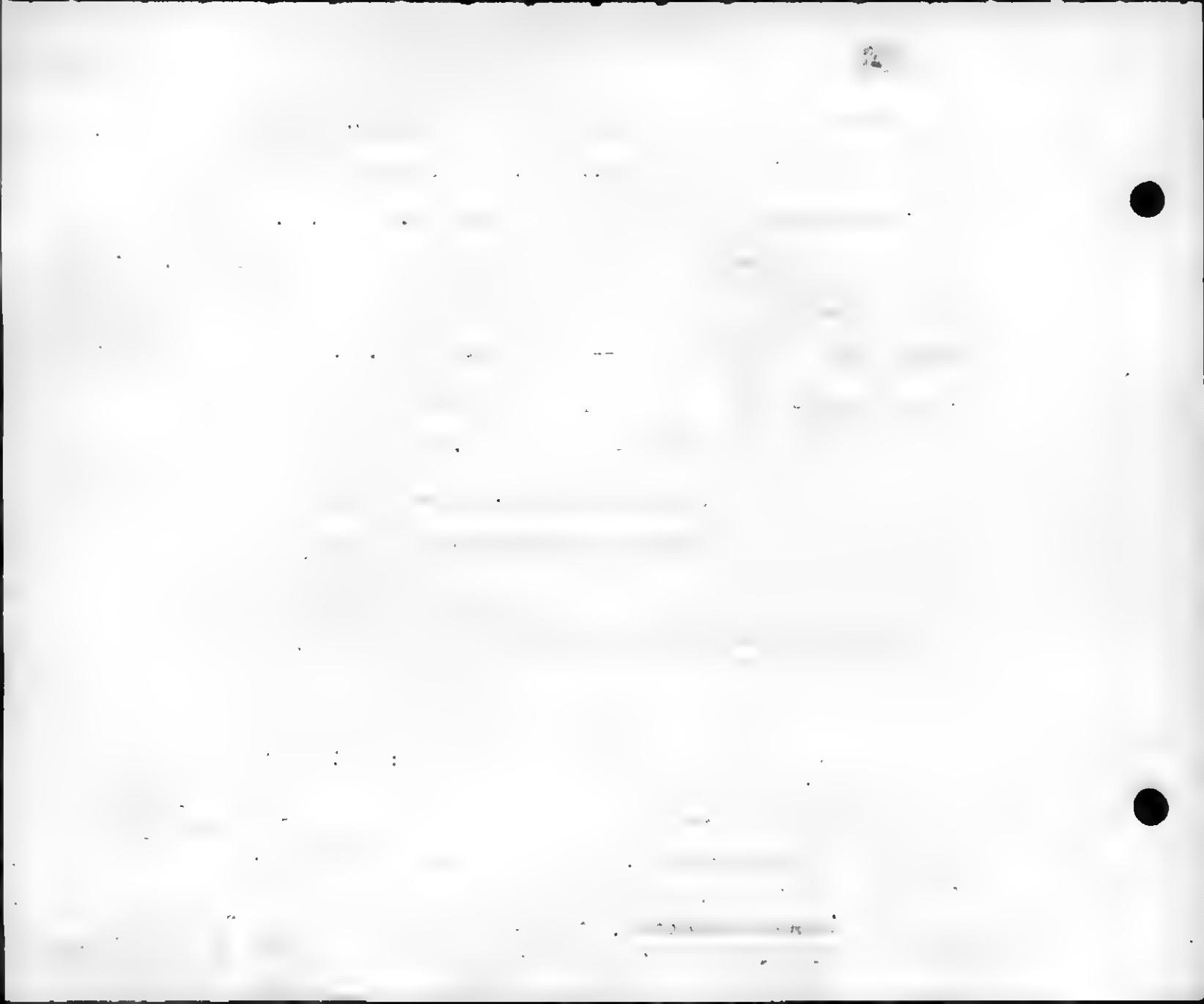


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.													
11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove return papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		12. PLACE OF DEATH a. COUNTY		13. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY									
		Prince Georges MARYLAND		D. C.									
		b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		Glenn Dale (rural)		6 mos., 9 dys		Washington		319 17th St. N. E.					
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)											
		Glenn Dale Hospital											
		3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
		Cassie				Portee	March	6	1966				
		5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days	Hours	Min.
		Female Negro				7/30/1919	46 yrs.						
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
		Kitchen Helper		---		Camden, S. C.		USA					
		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
		Arthur Reynolds		Laddie ?									
		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
		No ---		578-16-7854		Decedent							
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH			
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia with renal insufficiency								5 days			
		DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Acute and chronic pyelonephritis											
		DUE TO (c)											
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
		Pulmonary tuberculosis: diabetes mellitus <i>0021</i>											
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
		20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
21. I certify that <i>He</i> (this hospital) attended the deceased from 8/25 1:20 P.M. to 3/6, 1966, that <i>We</i> last saw the deceased alive on 3/6 1966, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED 3/6/66		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial 3/11/66		23b. DATE THEREOF 3/11/66		23c. NAME OF CEMETERY OR CREMATORIUM Lincoln Memorial Ceme.		23d. LOCATION (City, town or county) (State) Maryland		25a. REC'D BY REGISTRAR Edward Stewart 1001 MAR 10 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24. FUNERAL DIRECTOR <i>John T. Stewart</i>													



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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04262

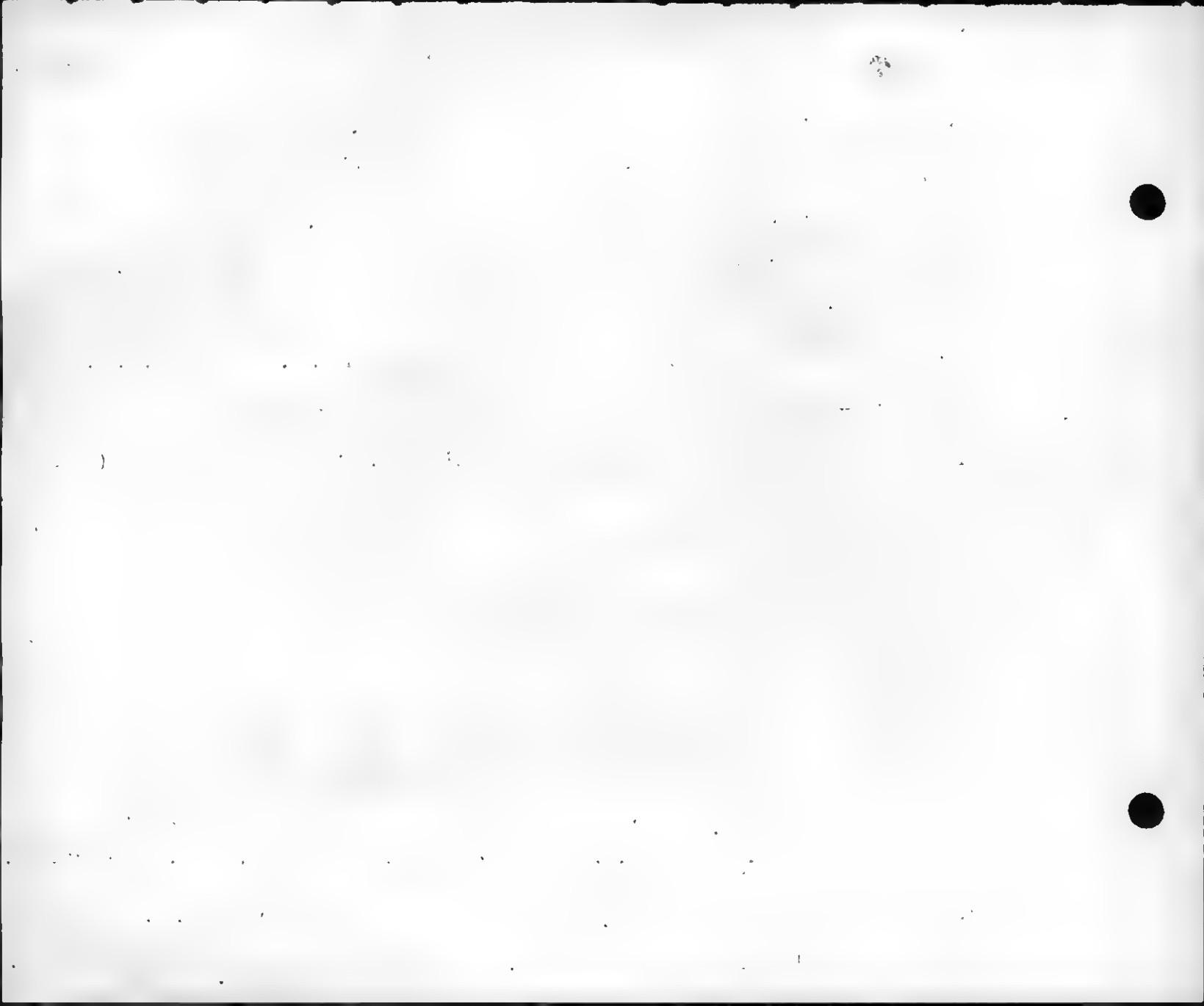
## CERTIFICATE OF DEATH

04255

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>5318 Gallatin Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Silas</b>	Middle <b>A</b>	Last <b>Porter</b>
4. DATE OF DEATH	Month <b>March</b>	Day <b>8</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-15</b>
9. AGE (in years last birthday) <b>50 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab driver</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington D.C.</b>	
13. FATHER'S NAME <b>John Andrew Porter</b>		14. MOTHER'S MAIDEN NAME <b>Alice Bell Clatterbuck</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578 03 9090</b>	17. INFORMANT <b>Genevieve D. Porter Same as #2 (wife)</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 1000 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia + Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 3</b> , 1966, to <b>March 8</b> , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 8</b> , 1966, and that death occurred at 6:05 P.M. from the causes and on the date stated above.		22b. DATE SIGNED <b>3/8/66</b>	
22a. SIGNATURE <i>Edwin J. Jensen</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>3/8/66</b>
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/10/66</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet</b>	
ADDRESS <b>Hyattsville, Md.</b>		23d. LOCATION (City, town or county) <b>Washington D.C.</b>	
		25a. REC'D BY REGISTRAR <b>DAR</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



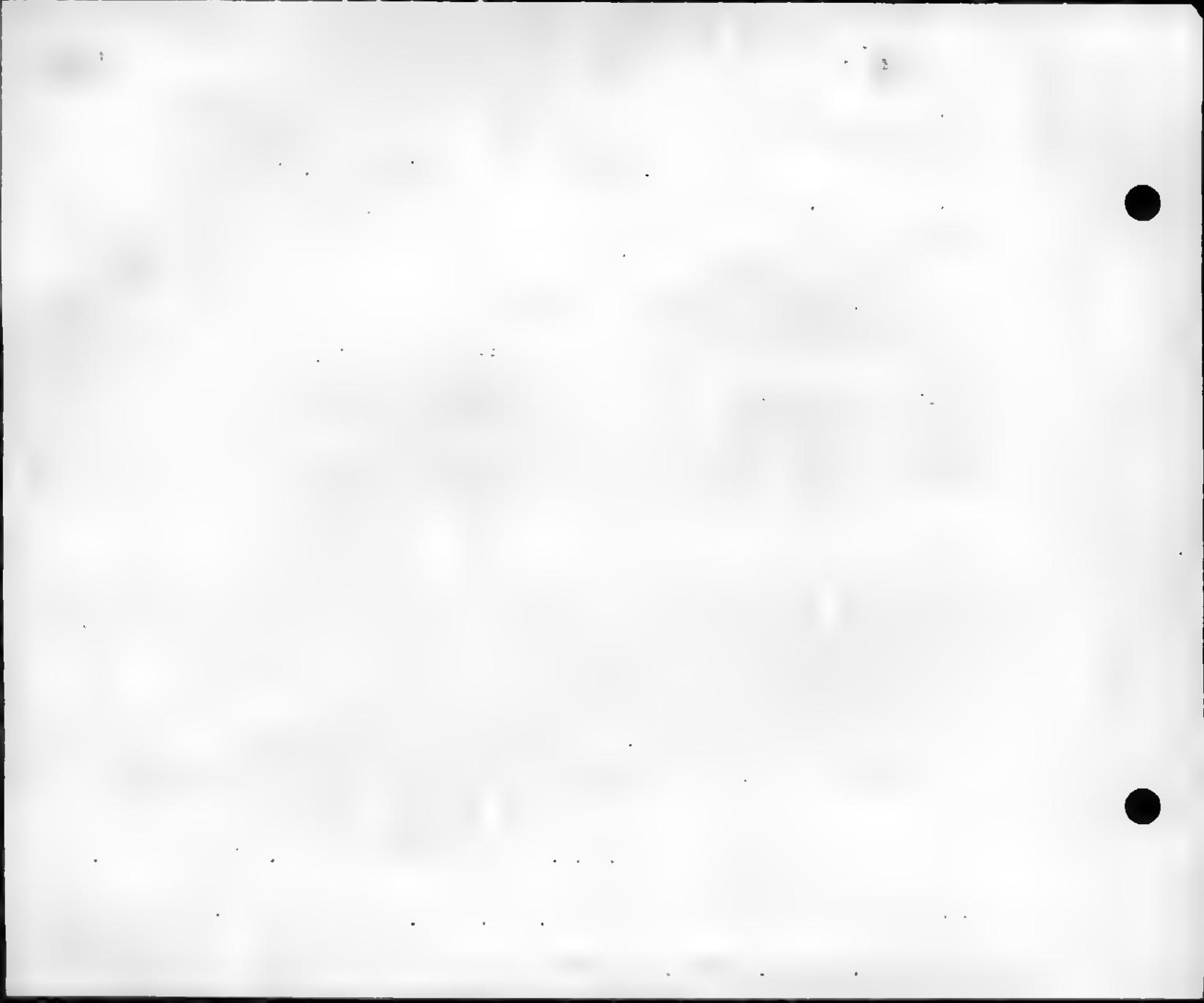
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and

should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event,

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN lb <b>3 hours</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <b>MD</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>			b. COUNTY <b>DC</b>								
3. NAME OF DECEASED (Type or print) <b>Baby</b>			First <b>Girl</b>			Last <b>Posey</b>			4. DATE OF DEATH <b>March 15 1966</b>								
5. SEX <b>Female</b>			6. COLOR OR RACE <b>Negro</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>March 15, 1966</b>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>			9. AGE (in years last birthday) <b>yrs.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Donald (NMN) Posey</b>			14. MOTHER'S MAIDEN NAME <b>Nelma (NMN) Posey</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>--</b>			17. INFORMANT <b>Address</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7625</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Bilateral Atrial fibrillation</b>			DUE TO (b) <b>Prematurity</b>			DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Riverdale Rd.</b>			20f. (City or town) <b>Riverdale</b>	(County) <b>Maryland</b>	(State) <b>Md.</b>
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>March 15, 1966</b> , to <b>March 15, 1966</b> , that <input type="checkbox"/> (we) last saw the deceased alive on <b>March 15, 1966</b> , and that death occurred at <b>8:00M</b> , from the causes and on the date stated above.			22a. SIGNATURE <b>Hernando Alvarado, M.D.</b>			22b. DATE SIGNED <b>3/15/66</b>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) <b>Hernando Alvarado, M.D.</b>			22d. ADDRESS <b>6201 Riverdale Rd. Riverdale, Md.</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>			23b. DATE THEREOF <b>3/19/66</b>			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Prince Geo. Gen. Hosp.</b>			23d. LOCATION (City, town or county) <b>Cheverly Maryland</b>		
24. FUNERAL DIRECTOR <b>William A. Parker, Assist. Administrator</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>DATE MAR 22 1966</b>											



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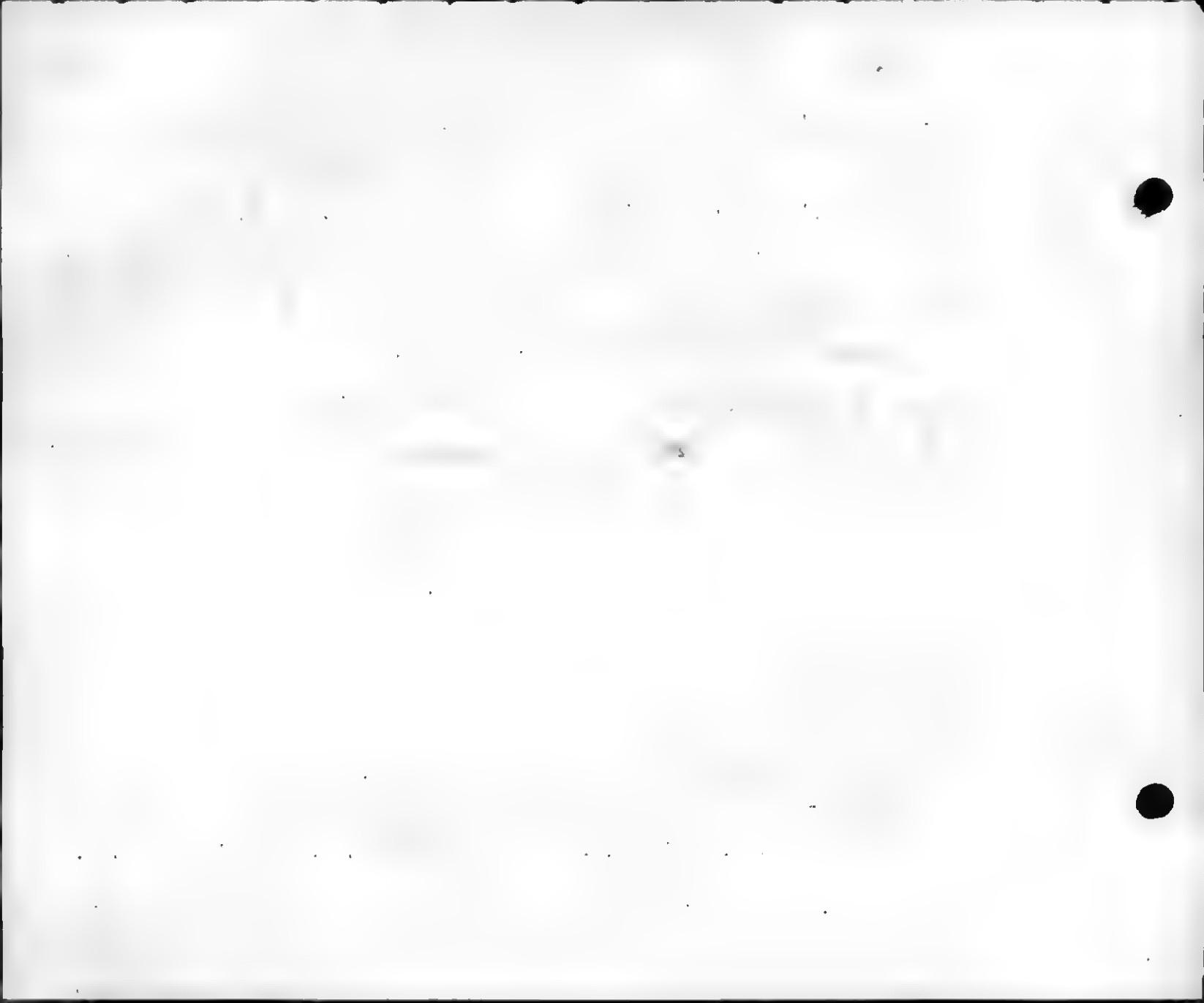
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

0264 114257

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 <b>Cheverly</b> 2 days		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		
3. NAME OF DECEASED (Type or print) <b>Rita</b>		First <b>Rita</b>	Middle <b>Ann</b>	
Last <b>Pullen</b>		4. DATE OF DEATH <b>March 15 1966</b>	Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		W100WE0 <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Wrapper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>grocery store</b>	8. DATE OF BIRTH <b>1-9-32</b>	
9. AGE (In years last birthday) <b>34 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (County & State, or foreign country) <b>PENNA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>SAMUEL D. BOUTERBAUGH</b>		14. MOTHER'S MAIDEN NAME <b>MARY HERHEI</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>172-26-8127</b>	17. INFORMANT <b>DONALD L. PULLEN</b>	Address <b>5300 LACKAWANNA COLLEGE PARK MD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  19a X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.  DUE TO (b) <i>Carcinoma RT. Breast (evirually removed 2 yr ago).</i>				
DUE TO (c) <i>removed 2 yr ago).</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERRLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>Feb 3, 1964, to Mar 14, 1966</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>MAR 14 1966</b> , and that death occurred <b>8:30 A.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>15 March 1966</b>		
22a. SIGNATURE <i>John H. Bayly</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	M.E.O. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>John H. E. Bayly, M.D.</b>		22d. ADDRESS <b>1835 Eye St. N.W. Washington, D.C.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>18 Mar 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Amsbury Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Amsbury, Pennia.</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale, Md.</b>		ADDRESS	25a. REG'D BY REGISTRAR <b>MAR 21 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



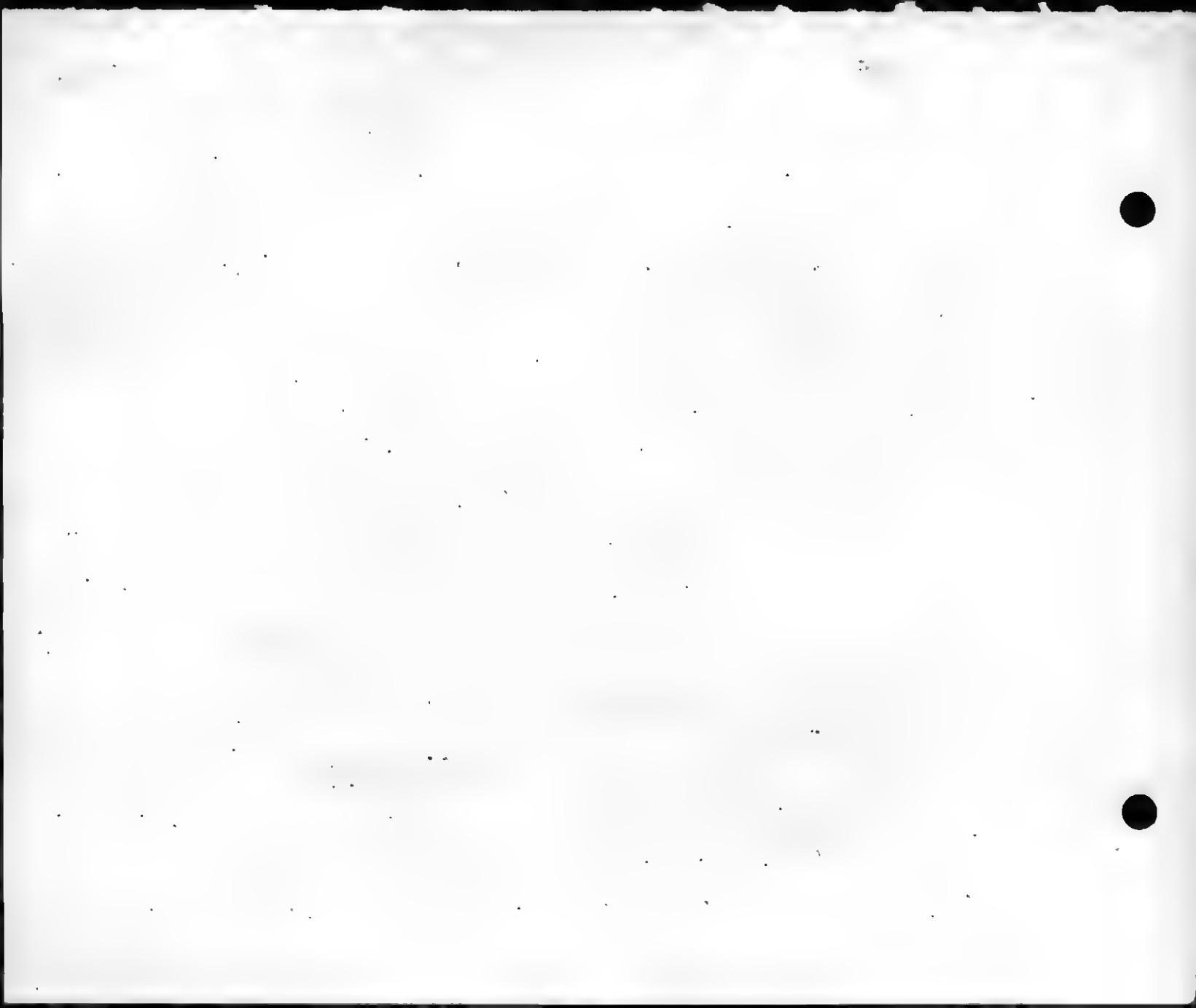
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

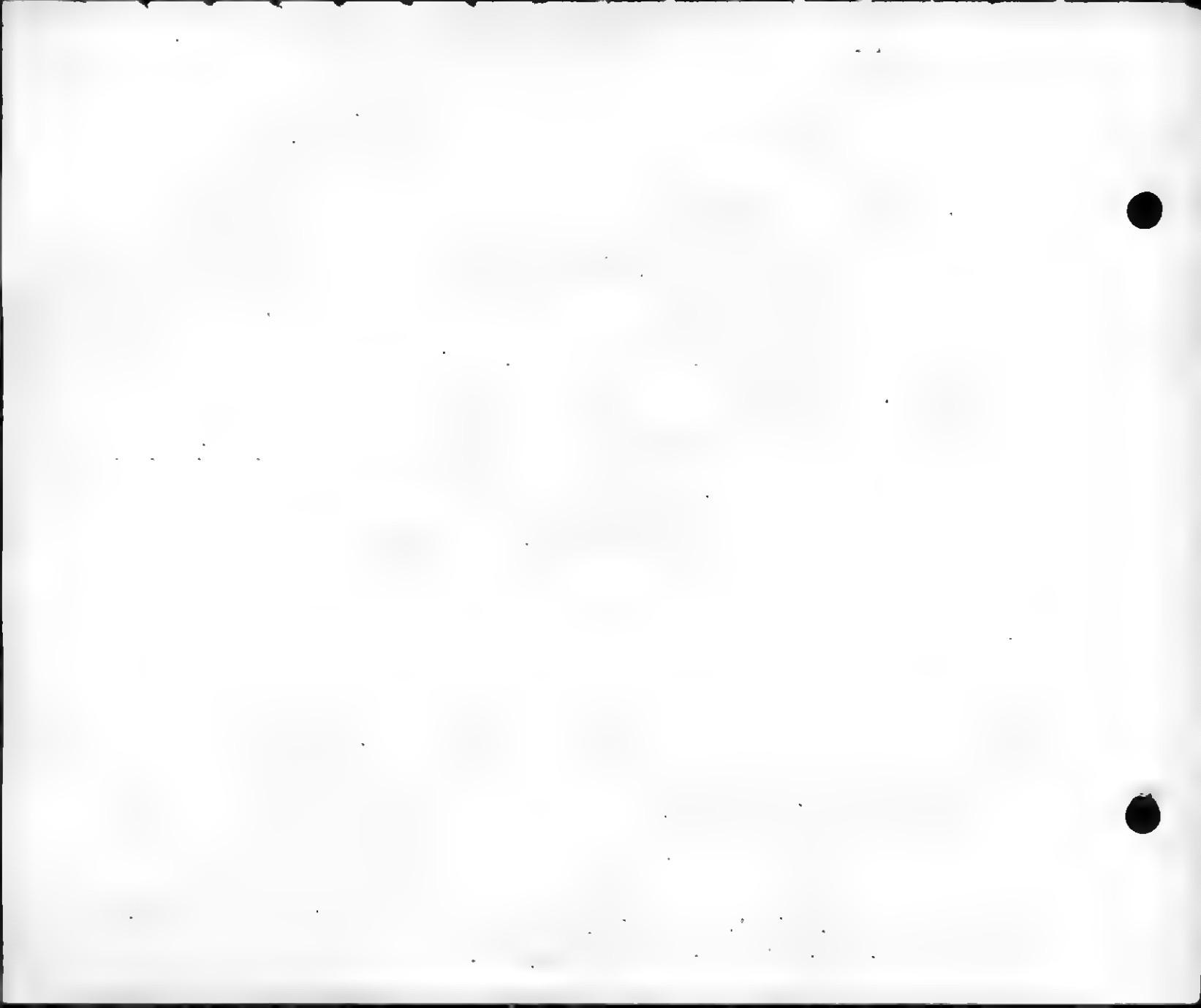
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <i>Prince George</i>				a. STATE <i>md</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake Md</i>				b. COUNTY <i>Prd. Ed.</i>									
c. LENGTH OF STAY IN 1B <i>DOA</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md</i>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Prince George General Hospital</i>				d. STREET ADDRESS <i>5620 Albermarle Place</i>									
3. NAME OF DECEASED (Type or print) <i>William Joseph Reilly</i>				First: <i>W</i>	Middle: <i>J</i>	Last: <i>R</i>	4. DATE OF DEATH <i>March 6 1966</i>	Month <i>March</i>	Day <i>6</i>	Year <i>1966</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>Male</i>				6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/6/15</i>	9. AGE (In years last birthday) <i>50 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Management analyst</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Queens Co New York</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>					
13. FATHER'S NAME <i>William Reilly, sr.</i>				14. MOTHER'S MAIDEN NAME <i>Amelia Stevens</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>578602356</i>				17. INFORMANT <i>Mary A. Reilly Hyattsville, Md</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure - Myocardial infarction, 30 min.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>									
42-1 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary sclerosis</i>				DUE TO <i>Arteriosclerosis</i>									
				DUE TO <i>Arteriosclerosis</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Myocardial infarction Aug 65</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <i>—</i>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>—</i> 19 p.m. <i>—</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>		(State) <i>—</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>10/29</i> , 19 <i>37</i> to <i>3/6</i> , 19 <i>66</i> , that (I) (s) last saw the deceased alive on <i>3/2</i> 19 <i>66</i> , and that death occurred at <i>3/6</i> M, from the causes and on the date stated above.				22b. DATE SIGNED <i>3/7/66</i>									
22a. SIGNATURE <i>E.H. Aschenbach</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <i>R. H. Aschenbach</i>				22d. ADDRESS <i>1841 Col. Rd. NW</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Mar 9, 1966</i>				23b. DATE THEREOF <i>Mar 9, 1966</i>				23c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven</i>				23d. LOCATION (City, town or county) <i>Columbia Md</i>	
24. FUNERAL DIRECTOR <i>F. Gasche sons Hyattsville, Md</i>				ADDRESS <i>—</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
								DATE <i>MAR 10 1966</i>					



**TO HOSPITAL OR ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY PRINCE GEO. CITY MARYLAND				a. STATE D.C. b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville -				c. LENGTH OF STAY IN 1D 3 weeks				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington -					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Nursing Home -				d. STREET ADDRESS 428 Taylor St NW				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First WILLIAM Middle (WMN) REIMER Last				4. DATE OF DEATH Mar 3 1966									
5. SEX M				6. COLOR OR RACE Wh.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-76		9. AGE (in years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor - Attributed U.S. Treasury Dept.				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME ANANDUS REIMER.				14. MOTHER'S MAIDEN NAME Eliza Jane Reimer									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. YES				17. INFORMANT Grace P. Reimer Address: Records 428 Taylor St. N.W., D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH Timmed.					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) Arteriosclerosis, generalized. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Nov 15, 1966 to present, 19 to last saw the deceased alive on 2/23 1966, and that death occurred at 12 M, from the causes and on the date stated above.													
22a. SIGNATURE William F. Simpson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 3/3/66					
22c. PHYSICIAN'S NAME (Type) William F. Simpson				22d. ADDRESS 6210 Nth Ave MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 7, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City, town or county) (State) Prince George's Co. Md.					
24. FUNERAL DIRECTOR John Thomas 847 Georgia Ave. Narron E. Pumphrey, Inc. Silver Spring, Md.				ADDRESS				25a. REC'D BY REGISTRAR MARY 7 1966 25b. REGISTRAR'S SIGNATURE					
VR A15 (4) 20M 1/65				DATE									



1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

**1. PLACE OF DEATH**  
a. COUNTY **Prince George**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Hyattsville**

**c. LENGTH OF STAY IN 1b**  
**MARYLAND**

**2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)**  
a. STATE **Maryland**  
b. COUNTY **Montgomery**

**c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)**  
**Chevy Chase**

**d. STREET ADDRESS**  
**5519 Prospect St.**

**e. IS RESIDENCE ON A FARM?**  
YES  NO

**3. NAME OF DECEASED (Type or print)**  
First **Laura** Middle **Fisher** Last **Richard**

**4. DATE OF DEATH**  
**3 - 6 - 1966**

**5. SEX** **F** **6. COLOR OR RACE** **W** **7. MARRIED**  NEVER MARRIED   
WIDOWED  DIVORCED

**8. DATE OF BIRTH**  
**5-30-1892**

**9. AGE (in years last birthday)** **73 yrs.** **10. IF UNDER 1 YEAR** **IF UNDER 24 HRS.**  
Months **3** Days **6** Hours **19** Min. **11. BIRTHPLACE (County & State, or foreign country)** **Buffalo, N.Y.**

**12. CITIZEN OF WHAT COUNTRY?** **USA**

**13. FATHER'S NAME** **ERNEST FISHER** **14. MOTHER'S MAIDEN NAME** **KOHLER**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)** **No** **16. SOCIAL SECURITY NO.** **NONE** **17. INFORMANT** **ROBERT S. FOOTE, 2017 RITTENHOUSE ST.**

**18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]**

**PART I. DEATH WAS CAUSED BY:**  
IMMEDIATE CAUSE (a) **Gonemonia**  
4/ix  
OUE TO  
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) **Virus**  
OUE TO  
(c)

**PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)**  
**Essential hypertension, cerebral thrombosis and right hemiplegia, progressive heart failure, congestive heart failure.**

**19. WAS AUTOPSY PERFORMED?**  
YES  NO

**20a. ACCIDENT WAS UNDERLYING** **20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)**

**20c. TIME OF INJURY** Month, Day, Year  
Hour a.m. **19** **20d. INJURY OCCURRED** While  Not While   
p.m. **at work** **at work**

**20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)** **20f. (City or town)** **(County)** **(State)**

**21. I certify that (I) (this hospital) attended the deceased from **Sept.**, 1940, to **March 6, 1966**, that (I) (we) last saw the deceased alive on **March 5, 1966**, and that death occurred at **7:15 A.M.** from the causes and on the date stated above.**

**22a. SIGNATURE** **Bertram F. Schaefer** **22b. DATE SIGNED** **March 6, 1966**

**22c. PHYSICIAN'S NAME (Type)** **BERTRAM F. SCHAEFER** **22d. ADDRESS** **1780 Mass. Ave. N.W. Wash. D.C.**

**23a. BURIAL, CREMATION, REMOVAL (Specify)** **23b. DATE THEREOF** **23c. NAME OF CEMETERY OR CREMATORIAL** **23d. LOCATION (City, town or county)** **(State)**

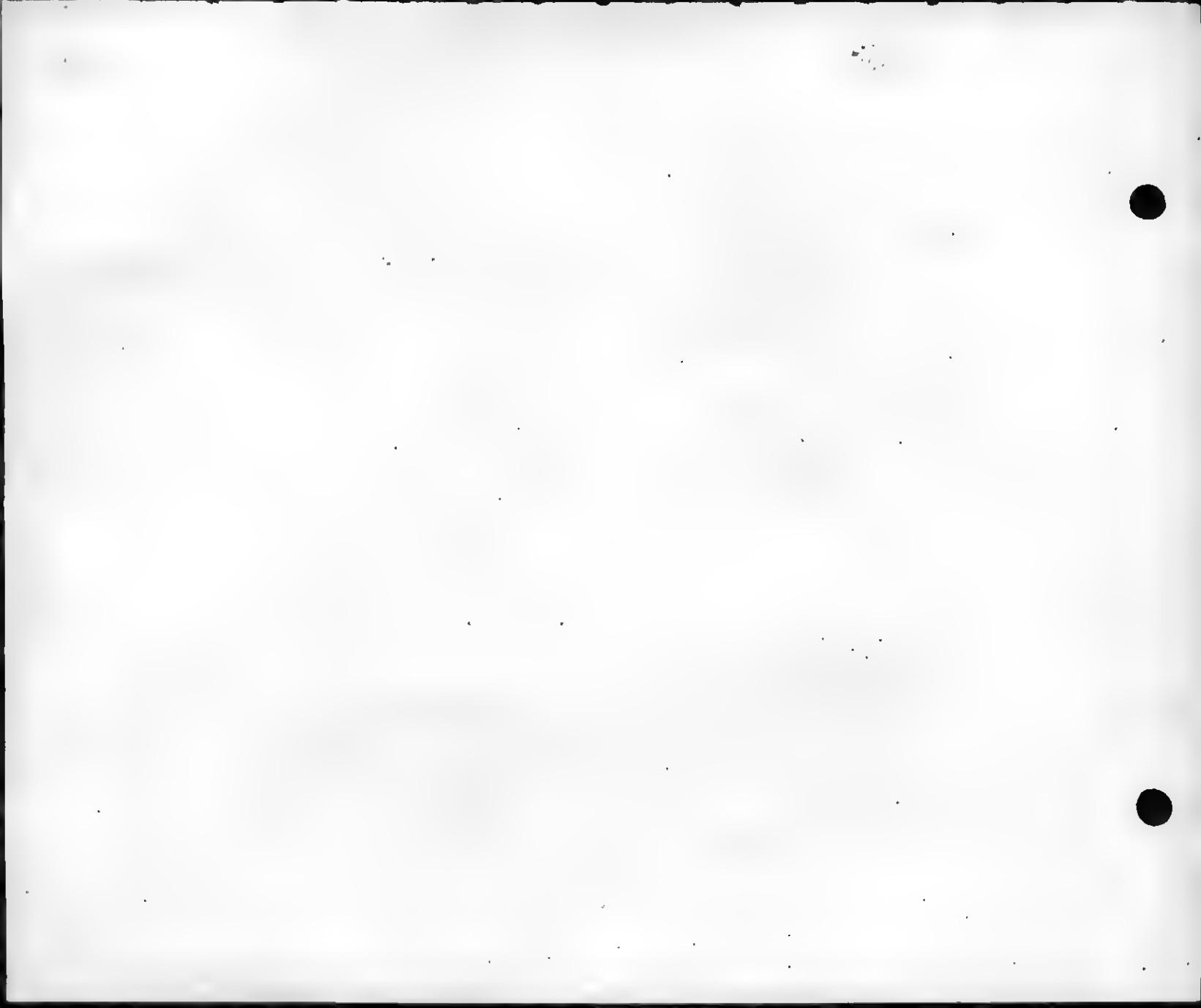
**Serical March 9, 1966** **LANCASTER RURAL CEMETERY** **LANCASTER** **N.Y.**

**24. FUNERAL DIRECTOR** **ADDRESS** **25a. REC'D BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE**

**J. Schaefer** **4101 Carroll St. N.W.** **D.C.** **MAR 8 1966** **Judge**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.



1 M

FOR STATE  
HEALTH DEPT.

Please execute the certificate, initial the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04268 104262

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5602 Eastpines Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LEO BERNARD RING</b>		4. DATE OF DEATH <b>March 17, 1966</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1903</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Ret. Accountant</b>	11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Maurice Ring</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Kinney</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>472 03 2833</b>		17. INFORMANT <b>Mrs. Leo B. Ring Same as #2 (wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, If any, which gave rise to immediate cause (b), stating the underlying cause last.  (b) <b>Nephrocalcinosis, bilateral, with "stag-horn" calculi</b>  DUE TO (c) <b>Chronic pyelonephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>19</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>Cheverly, Md 3/18/66</b>	
ACTUAL SIGNATURE <i>Cornelius J. Burns</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Cornelius J. Burns, M.D.</b>		Address (Street, city, town, or county) <b>Cheverly, Md 3/18/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/21/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DA MAR 21 1966</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be retained by the hospital or attending physician.

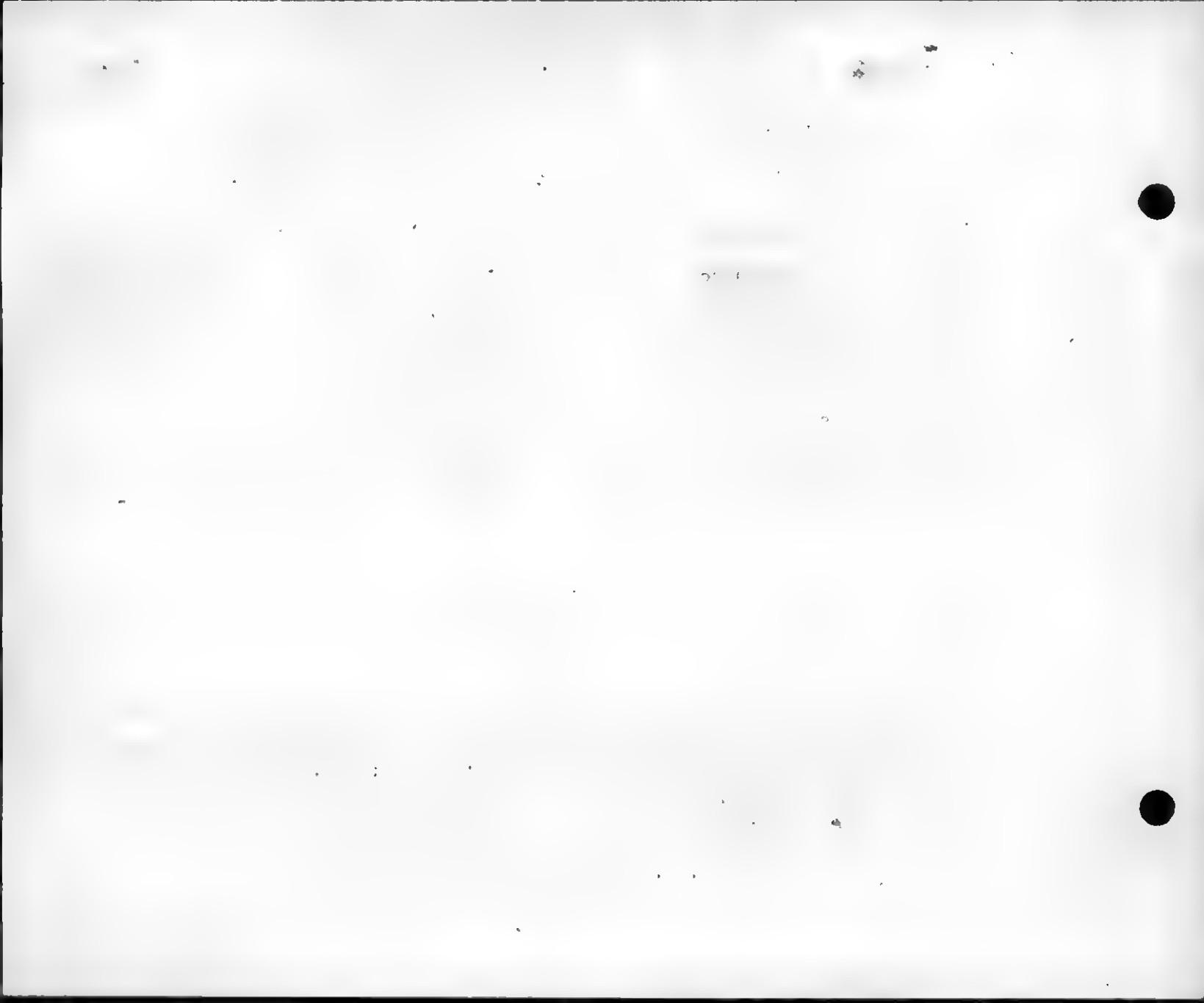
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 18, Part II, Film G388 5/15/67 cac

**CERTIFICATE OF DEATH**

04263

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 16 <b>1 mo. 24 days</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1445 Otis Pl., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Theodore</b>	Middle -	Last <b>Rinis</b> 4. DATE OF DEATH <b>3/13/1966</b> Month Month Day Year 19 66
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/1894</b> 9. AGE (In years last birthday) yrs. <b>71</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--- CLOTHING</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Minsk, Russia</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leon Rinis</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-03-3166</b>	17. INFORMANT <b>Decedent</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary occlusion (right coronary artery)</b> INTERVAL BETWEEN ONSET AND DEATH sudden			
45 / Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) Arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Tuberculosis</b> , <b>Bronchogenic carcinoma</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>---</b> 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 19 1966</b> to <b>March 13, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 13 1966</b> , and that death occurred at <b>---</b> M, from causes and on the date stated above.		22b. DATE SIGNED <b>3/13/66</b>	
22c. SIGNATURE <b>Moe Weiss</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS <b>Glenn Dale Hospital</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/15/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>ZION LEBAHOM, CEM.</b>
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		25a. RECEIVED BY REGISTRAR <b>MAR 15 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

04270

114264

## CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN lb

Five Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Sacred Heart Home

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

March 7 1966

Day Year

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED 

## 8. DATE OF BIRTH

August 17, 1875

WIDOWED DIVORCED 9. AGE (in years  
at birthday)  
90 yrs.IF UNDER 1 YEAR  
Months DaysIF UNDER 24 HRS.  
Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housework

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Washington, D. C.

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

David Riordan

## 14. MOTHER'S MAIDEN NAME

Nora O'Connell

Address

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Sacred Heart Home, Hyattsville, Md

INTERVAL BETWEEN  
ONSET AND DEATH

47 days

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

4200

## DUE TO

Conditions, if any, which  
gave rise to immediate cause

## (b)

(a), stating the underlying  
cause last.

## DUE TO

## (c)

ARTERIOSCLEROTIC HEART DISEASE

GENERALIZED ARTERIOSCLEROSIS 5 years

MEDICAL CERTIFICATION

## PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20e. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH

(If either, notify medical examiner)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

## 20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

## 20d. INJURY OCCURRED

## 20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

White  Not White at work  at work 

21. I certify that (I) (this hospital) attended the deceased from DEC 25, 1965, to MAR 7, 1966, that (I) (we) last saw the deceased alive on MAR 7, 1966, and that death occurred at 8 AM, from the causes and on the date stated above.

## 22a. SIGNATURE

Thomas F. Collins M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22b. DATE  
SIGNED

3-7-66

22c. PHYSICIAN'S  
NAME (Type)

THOMAS F. COLLINS

## 22d. ADDRESS

322- "H" ST NE

(State)

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

## 23b. DATE THEREOF

## 23c. NAME OF CEMETERY OR CREMATORIAL

## 23d. LOCATION (City, town or county)

(State)

Burial March 10/66

McClint Cemetery

Wash. D.C.

(State)

## 24 FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

## 25a. REC'D BY REGISTRAR

(State)

I F. Costello

1722 N. Cap St.

Wash. D.C.

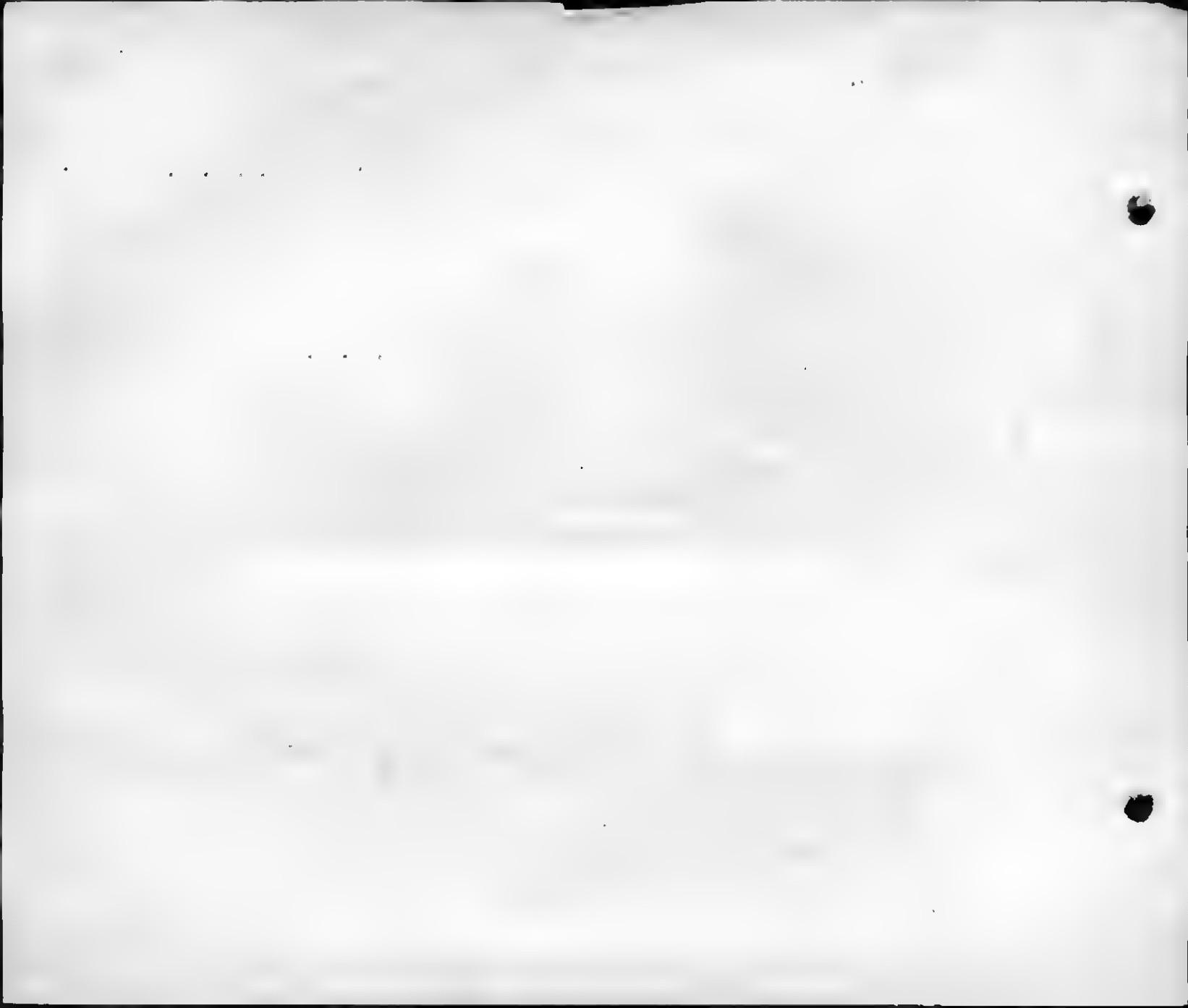
(State)

MAR 9 1966

1966

Charles J. ...

(State)



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

M

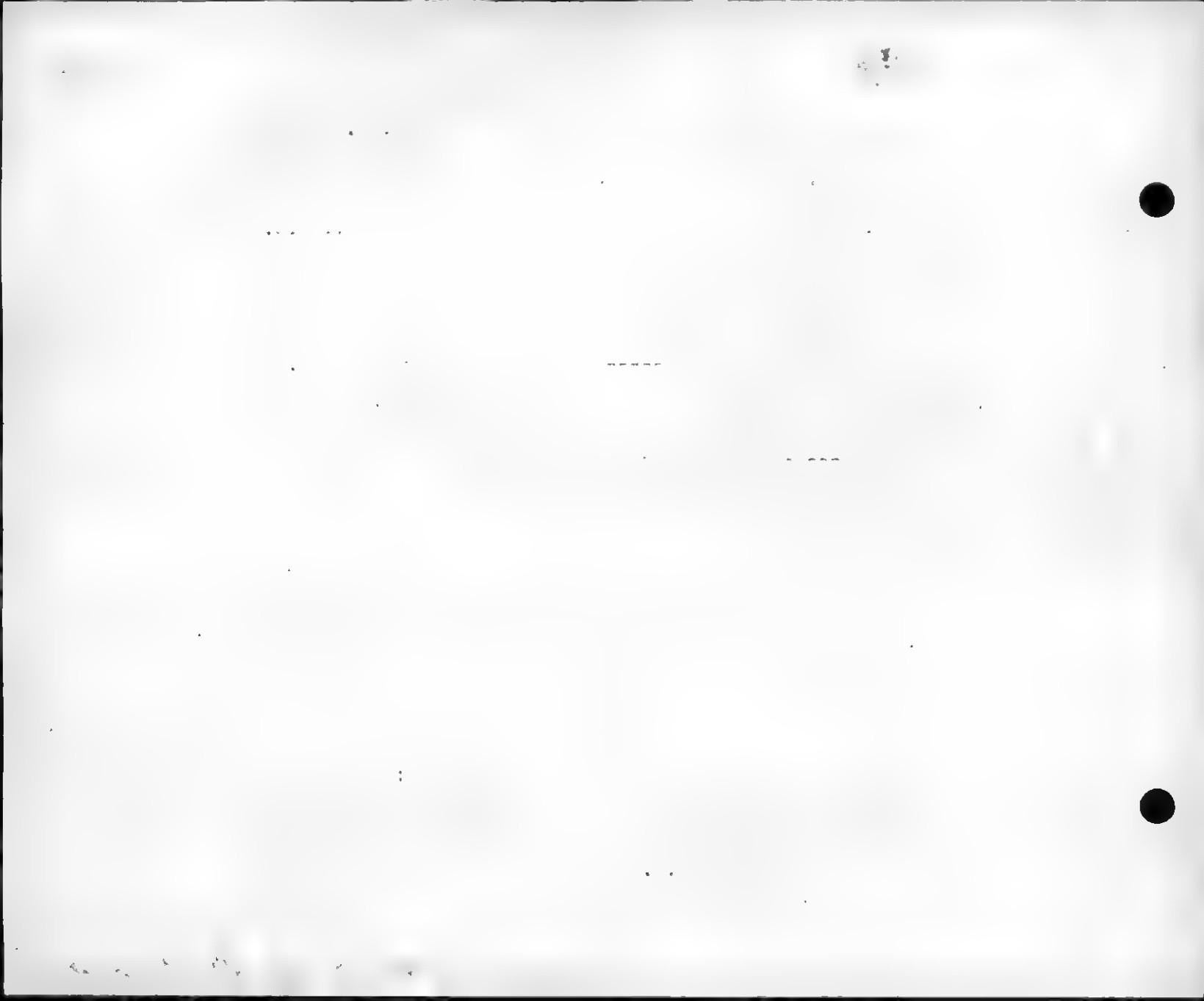
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04271

CERTIFICATE OF DEATH

04265

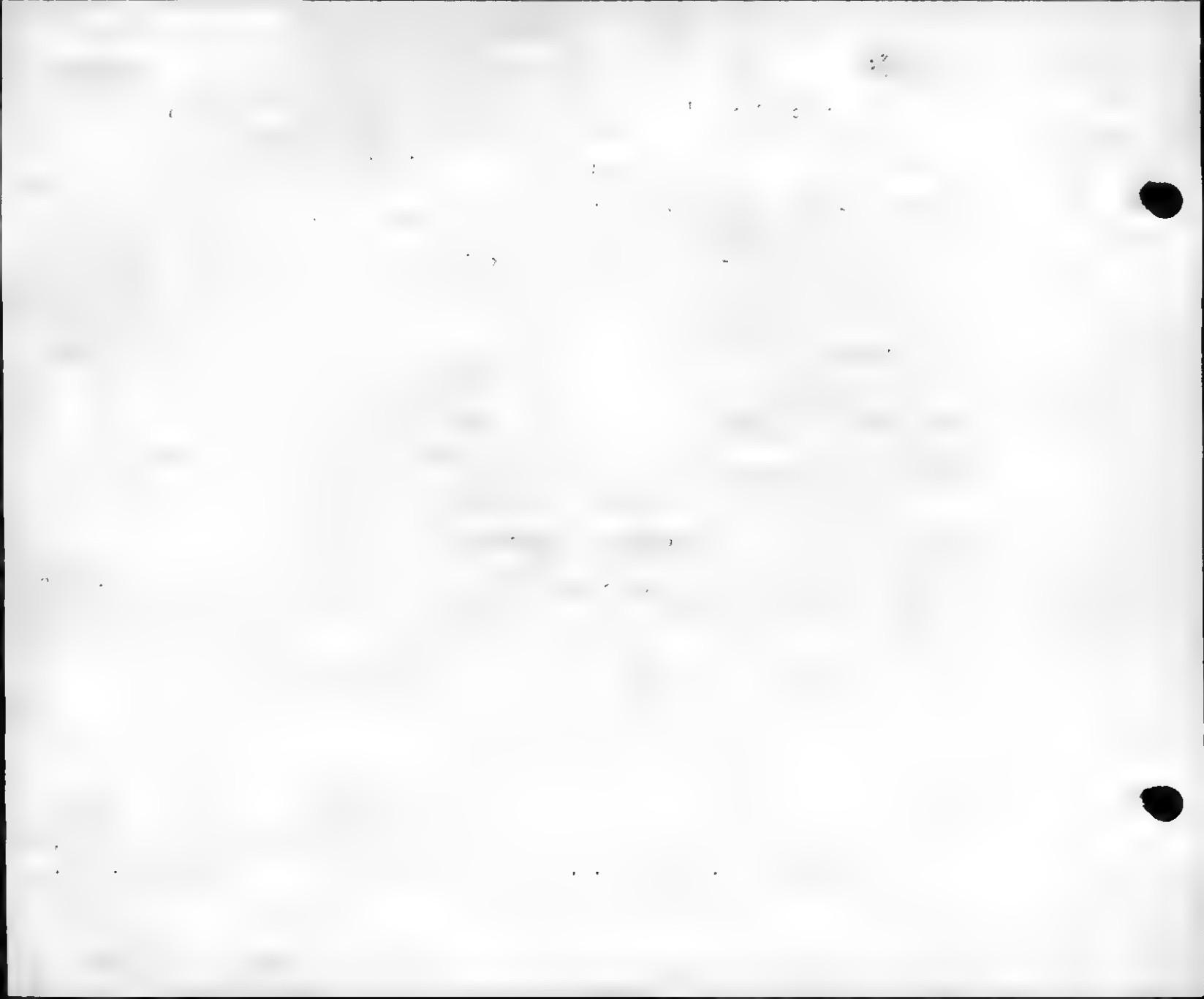
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Dale (rural)</b>	c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) <b>Glen Dale Hospital</b>		d. STREET ADDRESS <b>905 Kent St., N.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Charles</b>	Middle <b></b>	Last <b>Robinson</b>
4. DATE OF DEATH <b>March 20 1966</b>	Month Year	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>11/12/1881</b>	9. AGE (In years last birthday) <b>84 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Lumpkins, Ga.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Bou Robinson</b>	14. MOTHER'S MAIDEN NAME <b>Gussie ? ? ?</b>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No -----</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Decedent</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO <b>Carcinoma of the lower esophagus with metastases</b> (c) <b>to lymph nodes, lungs, liver, celiac plexus</b>		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE JERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>of tongue, resected by hemiglossectomy &amp; left radical neck dissection 1959; generalized arteriosclerosis with arteriosclerotic heart disease and amputated 11 fingers.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>carcinoma</b>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/18/1966</b> to <b>3/20/1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/20 1966</b> , and that death occurred on <b>3/20 AM</b> M, from causes and on the date stated above.			
22o. SIGNATURE <b>Moe Weiss</b>	MD ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/20/66</b>
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>	22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>		
23o. BURIAL/CREMATION, REMOVAL (Specify) <b>3-25-66</b>	23b. DATE THEREOF <b>3-25-66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland MD</b>
24. FUNERAL DIRECTOR <b>Universal 7 Home 816 Hst 78.</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 20 M 1/68			



1  
FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY			Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			b. STATE Maryland b. COUNTY Prince George's								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 35 minutes			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			d. STREET ADDRESS 316 Talbot Ave.								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Francis	Middle Leo	Last Robinson	4. DATE OF DEATH March 16 1966	Month March	Day 16	Year 1966									
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1909	9. AGE (in years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) New Britain, Conn.			12. CITIZEN OF WHAT COUNTRY? United States								
13. FATHER'S NAME <i>John Robinson</i>			14. MOTHER'S MAIDEN NAME <i>Ola Conaway</i>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. <i>224-16-8241</i>		17. INFORMANT Lillian Robinson (wife)		Address Same address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO Myocardial Infarction														
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			DUE TO Aplastic anemia						2 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>none</i>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>none</i>			20c. TIME OF INJURY Month, Day, Year Hour a.m. P.M. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Cornelius J. Burns</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (acting) March 16, 1966								
EXAMINER'S NAME (Type) Cornelius J. Burns, M.D.												Address (Street, city, town, or county) Cheverly, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-21-66			23c. NAME OF CEMETERY OR CREMATORIAL Balt National			23d. LOCATION (City, town or county) Baltimore Md			(State)					
24. FUNERAL DIRECTOR David Donaldson, Laurel, Md.			ADDRESS			25a. REC'D BY REGISTRAR MAR 22 1966			25b. REGISTRAR'S SIGNATURE Charles Judge								



1 M

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, doing with form PM3. Page 5 may be retained for your files.

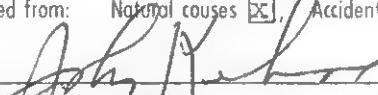
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

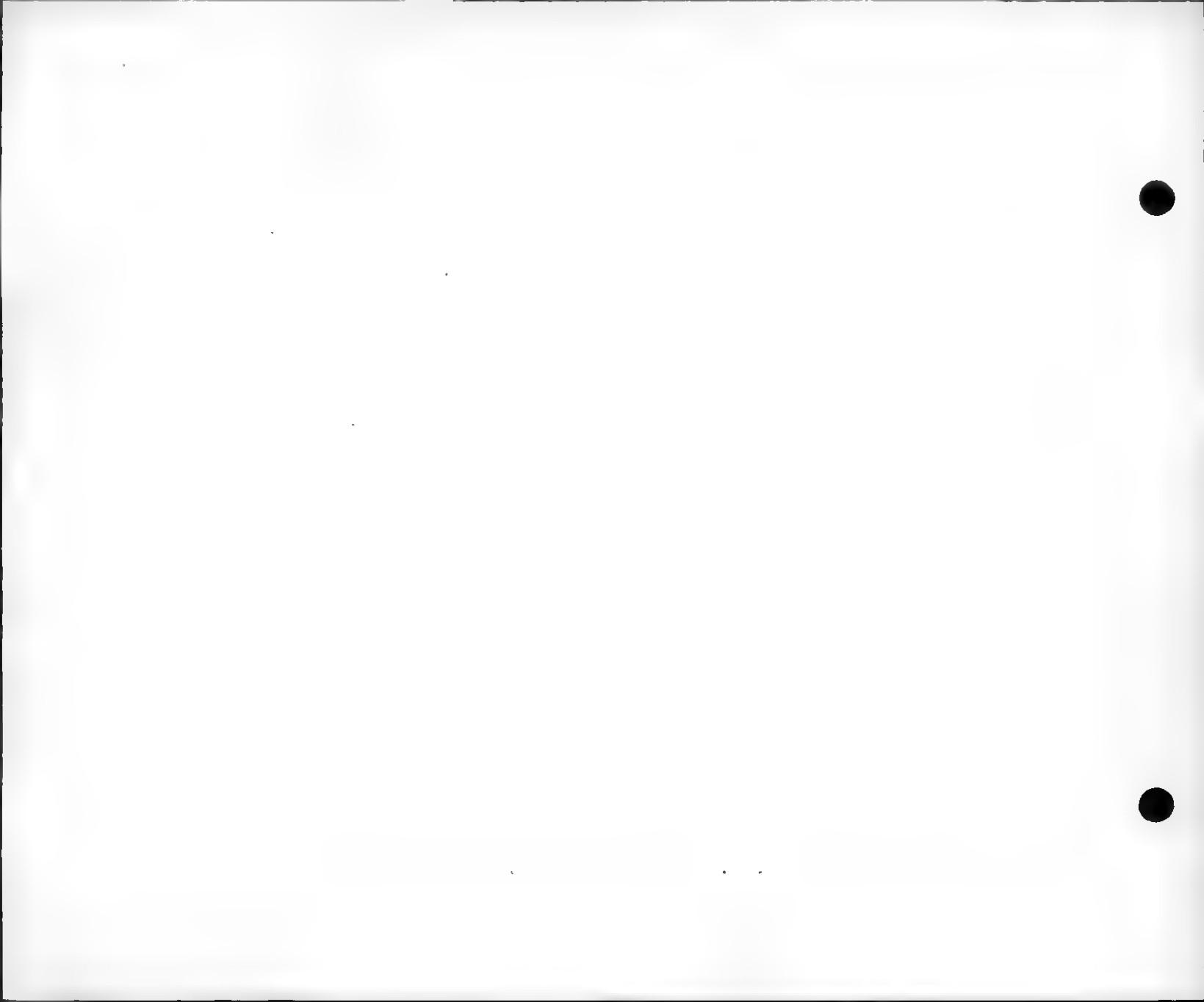
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04278

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04267

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if instit or Residence before admission) b STATE Maryland		
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e STREET ADDRESS 8214 Quentin Street		
3 NAME OF DECEASED (Type or print) Robin Lynn Robinson		4 DATE OF DEATH 3 1 19 66		
S SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED	8 NEVER MARRIED DIVORCED	
9. AGE (In years lost birthday) 2 yrs		F UNDER 1 YEAR Months Days Hours Min	F UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY None		
11 BIRTHPLACE (State or foreign country) Barberton, Ohio		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Raymond L. Robinson				
14. MOTHER'S MAIDEN NAME Kau Ann Kitchen		Address Quentin Street Hyattsville, Md.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		
17. INFORMANT Raymond L. Robinson		18. INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
PART I CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 4341 Conditions, if any, which gave rise to immediate cause (a) (b) From congestive heart failure stating the underlying cause lost. DUE TO (c)				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b) Hydrocephalus (surgically removed repaired-old)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour p.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				22. DATE SIGNED 3-2-66
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 4, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md.
24. FUNERAL DIRECTOR C. Glenn Carter		24b. ADDRESS 8034 Georgia Avenue	25a. REC'D BY REGISTRAR MAR 4 1966	25b. REGISTRAR'S SIGNATURE Warren E. Pumphrey, Inc. Silver Spring, Maryland



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

M  
04274

04268

**TO HOSPITAL:** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Laurel

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Laurel General Hospital

3. NAME OF DECEASED  
(Type or print)

First

Middle

PHYLLIS

PAGE

RODBELL

5. SEX

6. COLOR OR RACE

Female

White

WIDOWED

DIVORCED

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

22 Oct. 1927

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

John H. Burkley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

No

16. SOC. SEC. NO.

17. INFORMANT

578-26-2516 Herbert Rodbell

Same as 2  
Address

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY,  
IMMEDIATE CAUSE (e)

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(e), stating the underlying  
cause last. } (b)

DUE TO

(c)

Metastatic carcinoma

Uterine carcinoma

INTERVAL BETWEEN  
ONSET AND DEATH

8 mo

9 mos

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  (If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY  
Hour a.m.  
p.m.Month, Day, Year  
1920d. INJURY OCCURRED  
While at work  Not While at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from August, 1965, to 3-9, 1966, that (I) (we) last saw the deceased alive on 3-9, 1966, and that death occurred at 2 PM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)

Frank L Weaver Jr.

M.D.  
ATTENDING  
PHYS.MED.  
DIRECTOR  
STAFF  
PHYS.22b. DATE  
SIGNED  
Mar. 10, 1966

22d. ADDRESS

320 Montgomery Ave.  
Laurel, Maryland23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial 13-13-66

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIALy

23d. LOCATION (City, town or county)

(State)

Geo. Wash. Cemetery

Hyattsville

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

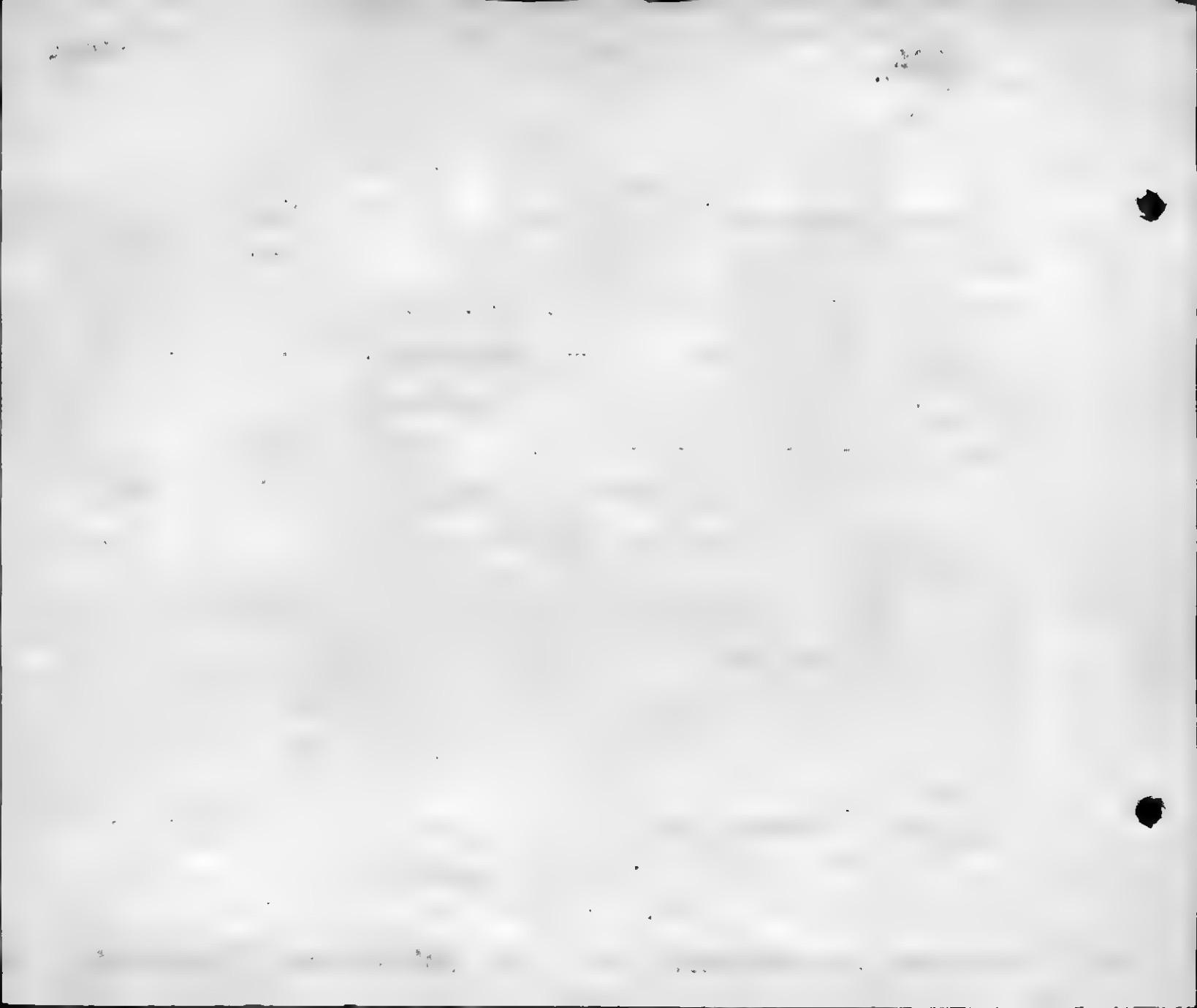
ADDRESS

Goldberg Funeral Home 4217-945th St. MAR 14 1966

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

VR A15 (4)  
15M 9/60



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.**



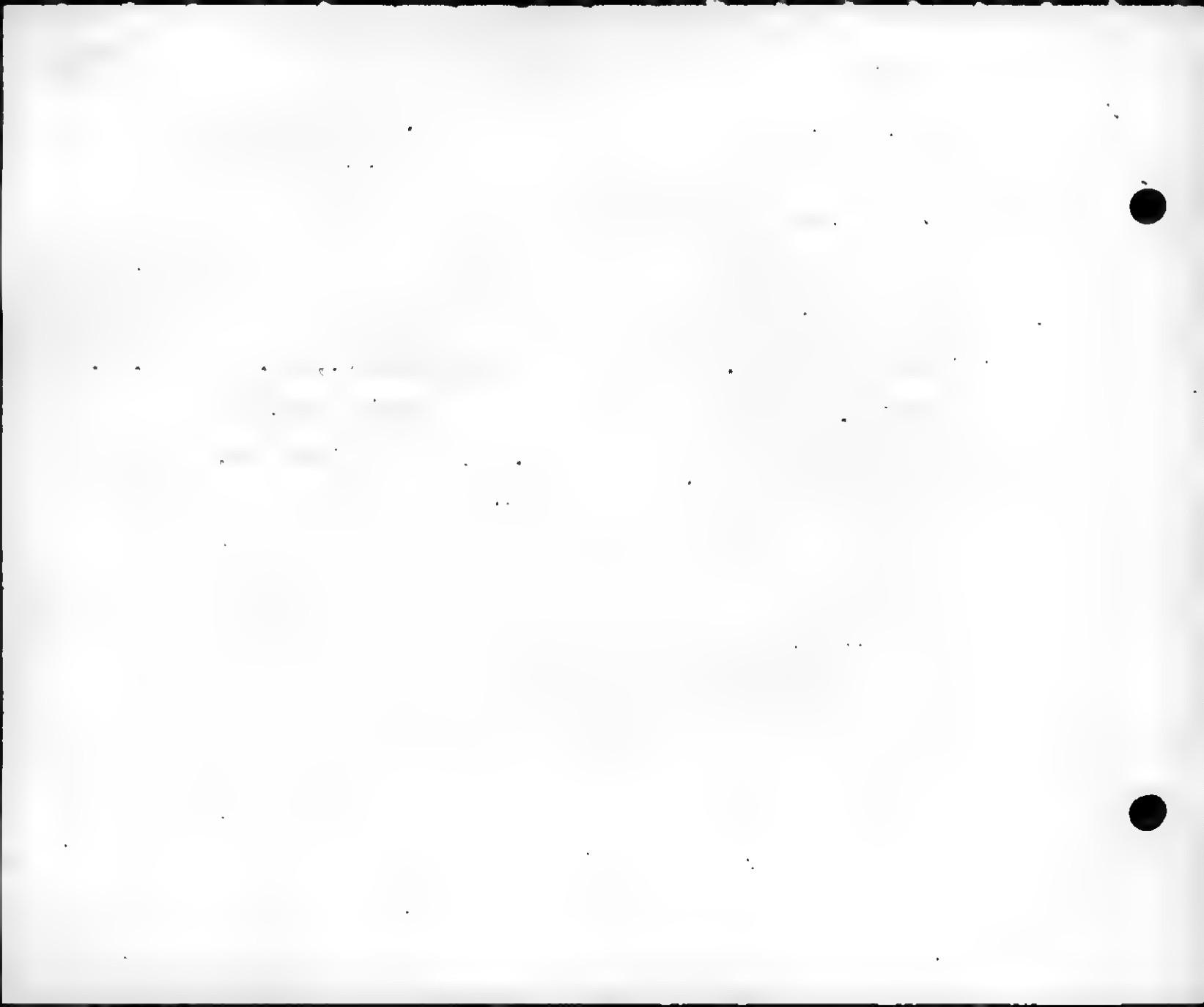
04275

**CERTIFICATE OF DEATH**

04260

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>3506 Perry Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>George</b>	Middle <b></b>	Last <b>Ryan</b>	
4. DATE OF DEATH Month Day Year <b>March 30 1966</b>	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2/22/10</b>	9. AGE (In years last birthday) <b>56 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Union Sta.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mail</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Culpeper Co., Va.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	13. FATHER'S NAME <b>Samuel E. Ryan</b>		
14. MOTHER'S MAIDEN NAME <b>Bertie Pullian</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>J. Hugh Ryan Culpeper, Virginia</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Dystrophy</i> DUE TO <i>Arteriosclerosis Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO <i></i> (c) <i></i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i> (County) <i></i> (State)
21. I certify that (X) (this hospital) attended the deceased from <b>March 28, 1966</b> , to <b>March 30, 1966</b> , that (X) (we) last saw the deceased alive on <b>March 30, 1966</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <i>Joselito Magday</i>		a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	22b. DATE SIGNED <i>3-30-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Joselito Magday</i>		22d. ADDRESS <i>Prince George's General Hospital</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-30-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fairview Cemetery</i>	23d. LOCATION (City, town or county) <i>Culpeper, Va.</i> (State)
24. FUNERAL DIRECTOR <i>Cloverfield Mortuary &amp; Crematory</i>		ADDRESS <i>415 S Main St.</i>	25a. REC'D BY REGISTRAR <i>APR 1 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Jeanne Judge</i>

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

04276

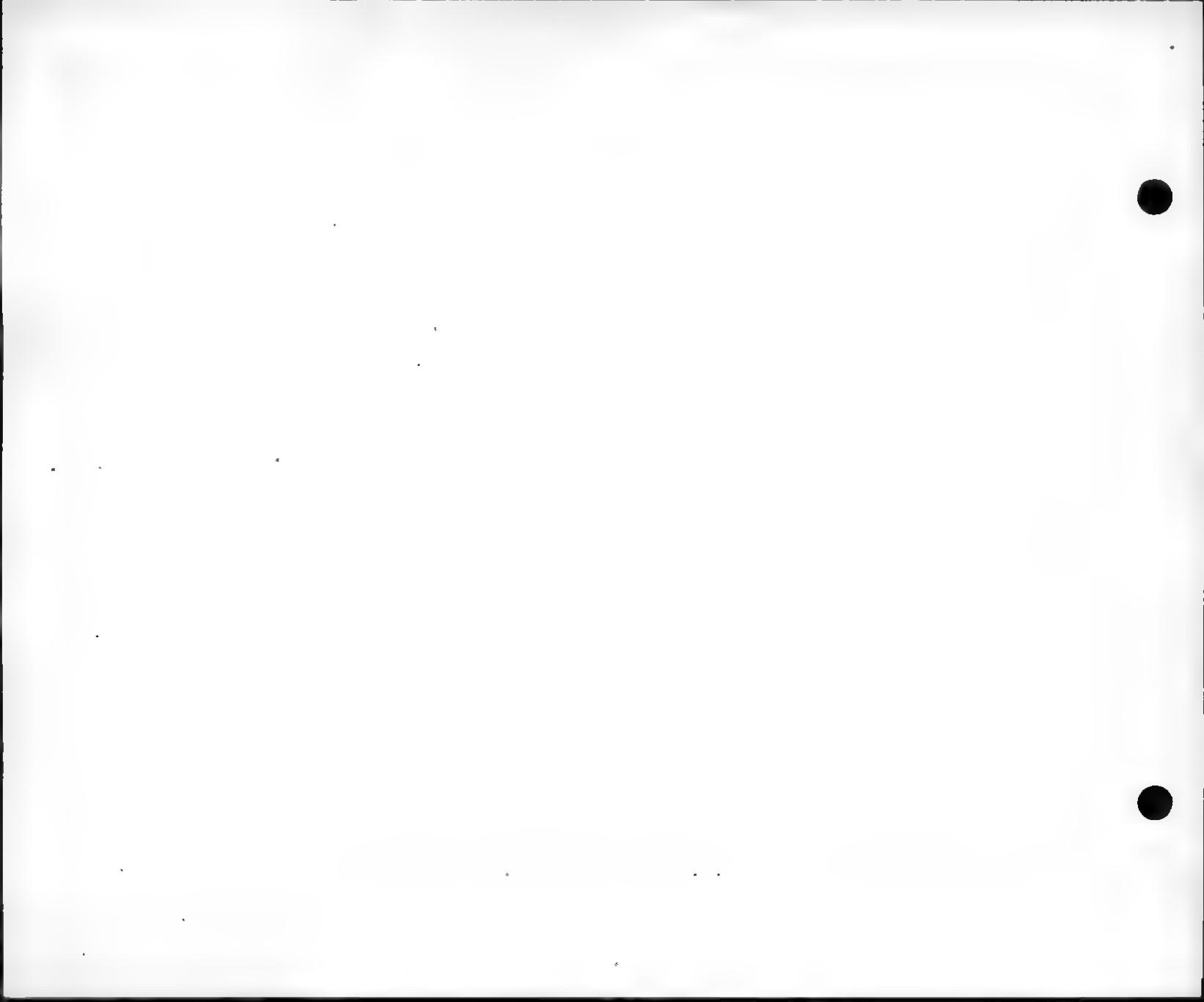
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04270

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 and 4 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased resided, if in institution, Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Vernon		First N	Middle Sanford, SR
4 DATE OF DEATH 3 21 19 66	Month Month	Day Days	Year Hours
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED	NEVER MARRIED DIVORCED
8a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Care Taker		8b DATE OF BIRTH 14 Aug. 1901	
9 AGE (In years last birthday) 64 yrs		10a KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) Washington, DC.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Walter Sanford	
14 MOTHER'S Maiden Name Unknown		15 INFORMANT #4 Austin Court Vernon N. Sanford, Jr. College Park, Md.	
16 SOC. SECURITY NO 577-14-7580		17 INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia, bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH	
491X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) (c)		DUE TO	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) John Kehoe, N.D. Riverdale, Md.		22. DATE SIGNED 3-22-66	
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF March 25-1966	
23c NAME OF CEMETERY OR CREMATORIUM Washington National Cemetery		23d LOCATION (City or Town) (County) (State) , Suitland, Maryland	
24 FUNERAL DIRECTOR Simmons Bros.		ADDRESS 1661-Gd. Hope RD. SE. Wash., DC	
25a RECEIVED BY REGISTRAR MAR 24 1966		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04277

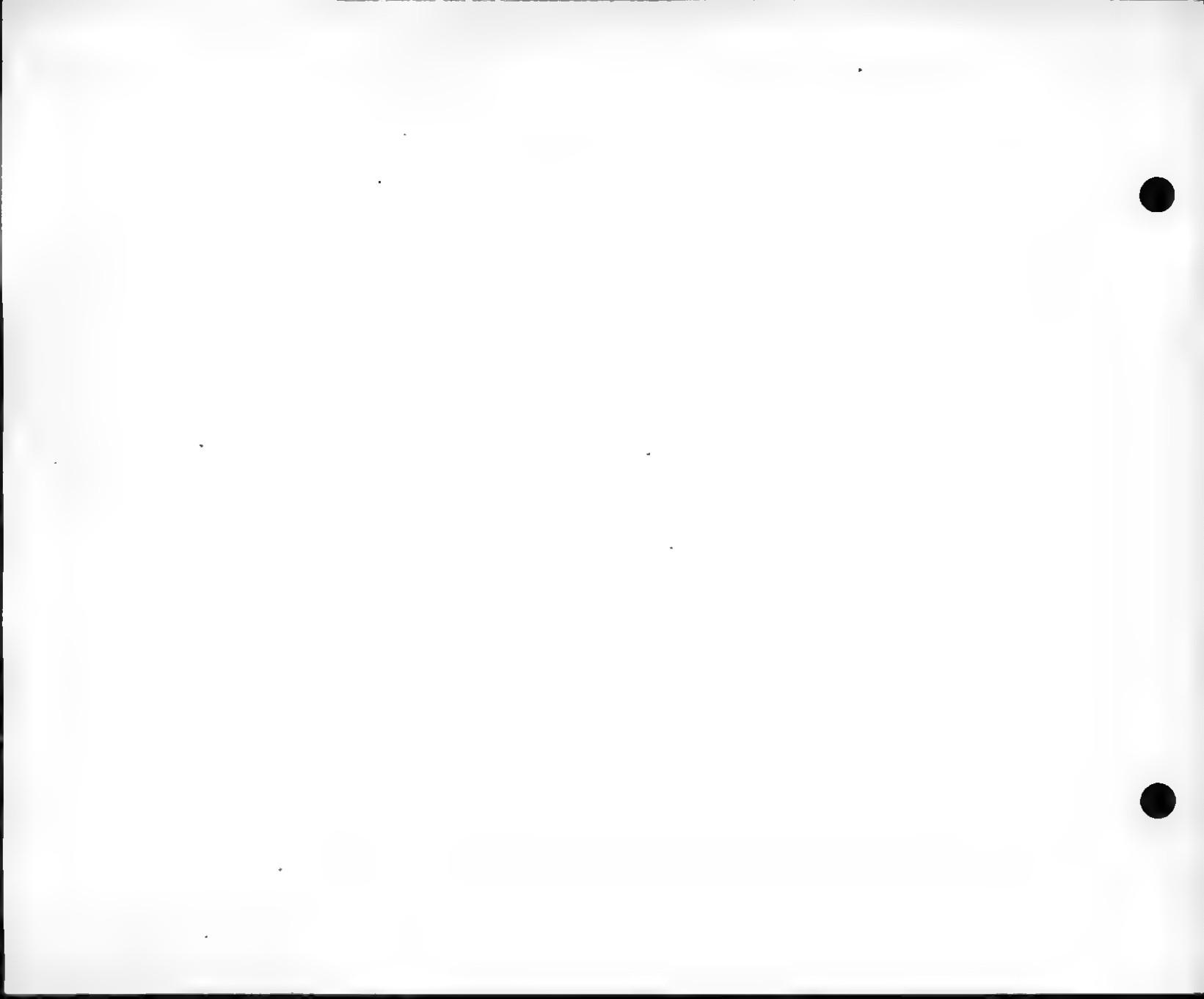
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04271

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		d. STREET ADDRESS <b>10401 46th Avenue</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Lester</b>	Middle <b>Albert</b>	Last <b>Schettig</b>	4. DATE OF DEATH Month <b>March</b>	Year <b>12 19 66</b>	Month <b>March</b>	Day <b>12</b>	Year <b>19 66</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1904</b>	9. AGE (In years last birthday) <b>61 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>APARTMENT MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ALBERT SCHETTIG</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>206-05-2503</b>		17. INFORMANT <b>MRS. CLARINDA SCHETTIG</b>		Address <b>10401 46th Ave BELTSVILLE, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b>		DUE TO <b>4200</b>		INTERVAL BETWEEN ONSET AND DEATH minutes				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Arteriosclerotic heart disease</b>		(b) DUE TO <b>last.</b>						
(c)						unknown		
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22. DATE SIGNED <b>3-12-66</b>
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				Address (Street, city, town, or county) <b>RIVERDALE, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>16 MARCH 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>GATE OF HEAVEN</b>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <b>WW. CHAMBERS CO.</b>		ADDRESS <b>RIVERDALE, MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



FOR STATE  
HEALTH DEPT.

M  
1  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P-3. Page 5 may be retained for your files.

2  
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

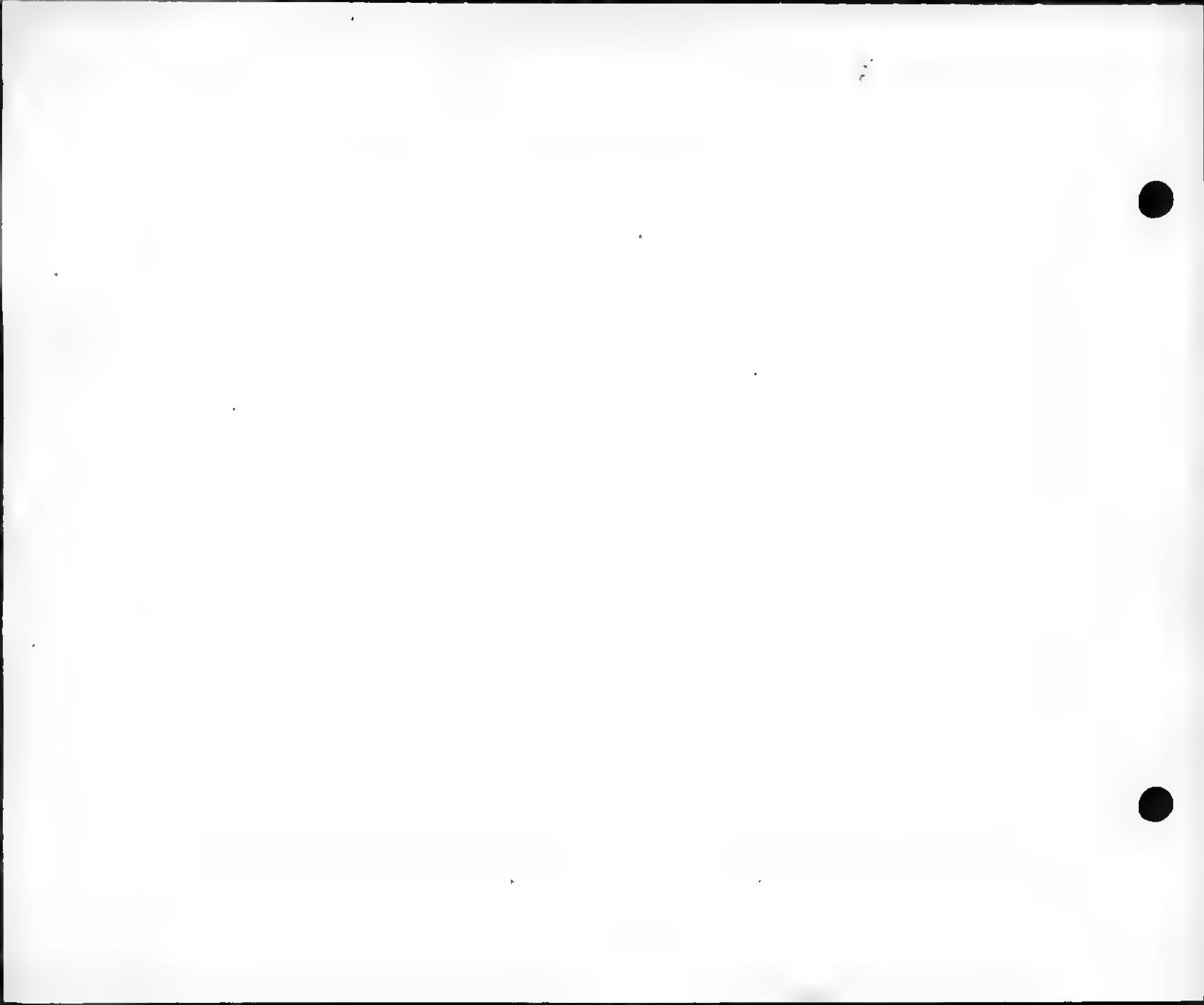
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04278

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04278

1 PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hosp.		e. STREET ADDRESS 3620 Fulton Avenue	
3. NAME OF DECEASED (Type or print) William L. Scrivner		4. DATE OF DEATH 3 15 1966	
S. SEX Male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	8 DATE OF BIRTH 2-6-1914
9 AGE (In years lost birthday) 52 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KND OF BUSINESS OR INDUSTRY Farm
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James Scrivner		14 MOTHER'S MAIDEN NAME Elizabeth Oten	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Helen Scott - Sister		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure		INTERVAL BETWEEN ONSET AND DEATH minutes	
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		over 2 yrs	
(b) Arteriosclerotic heart disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (Country) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-21-1966	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery, Bladensburg, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Henry S. Washington & Sons-4925 N. Main St. NE		ADDRESS	
25a. RECEIVED BY REC'D BY MAR 24 1966		25b. REC'D BY REC'D BY Signature	



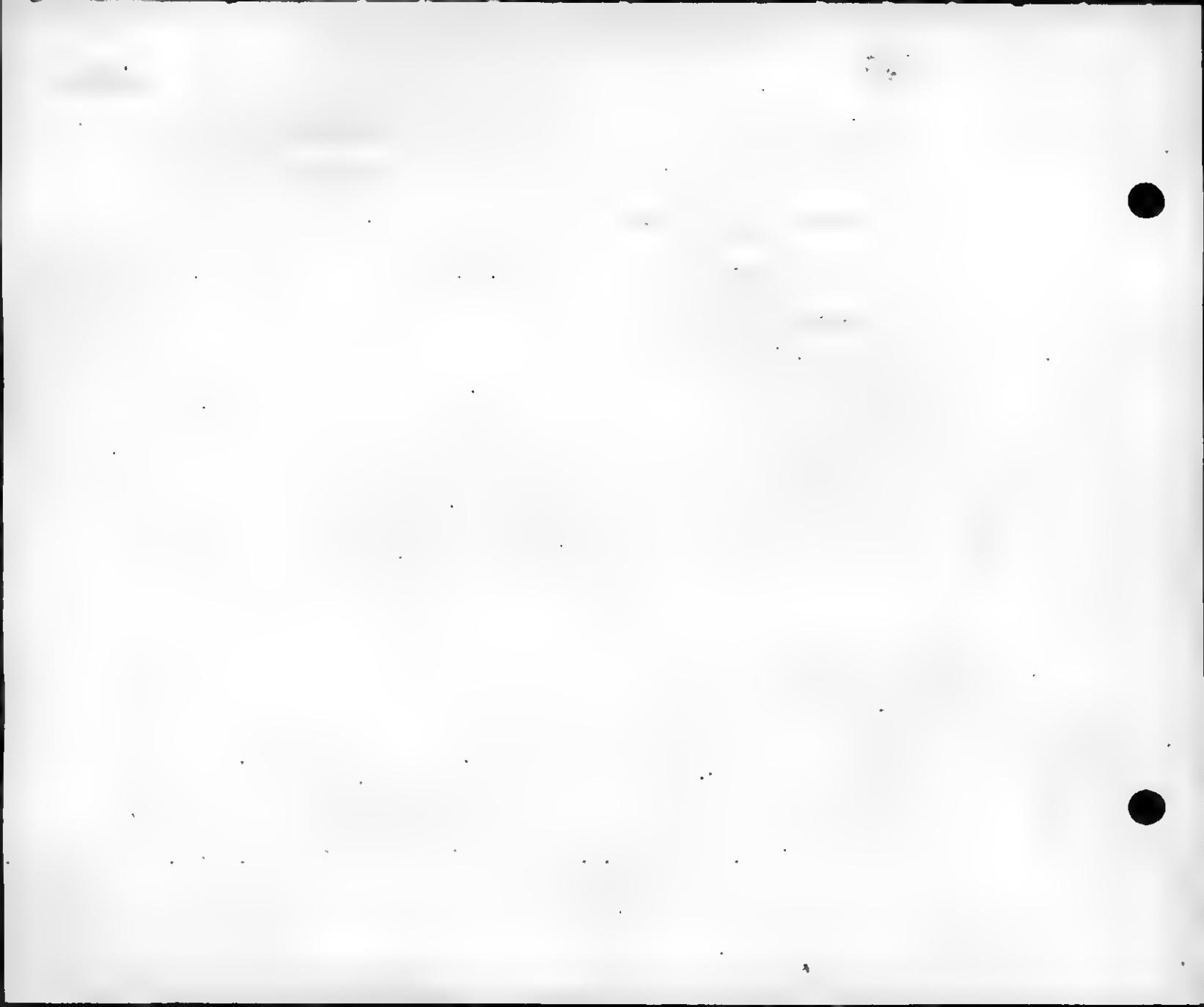
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

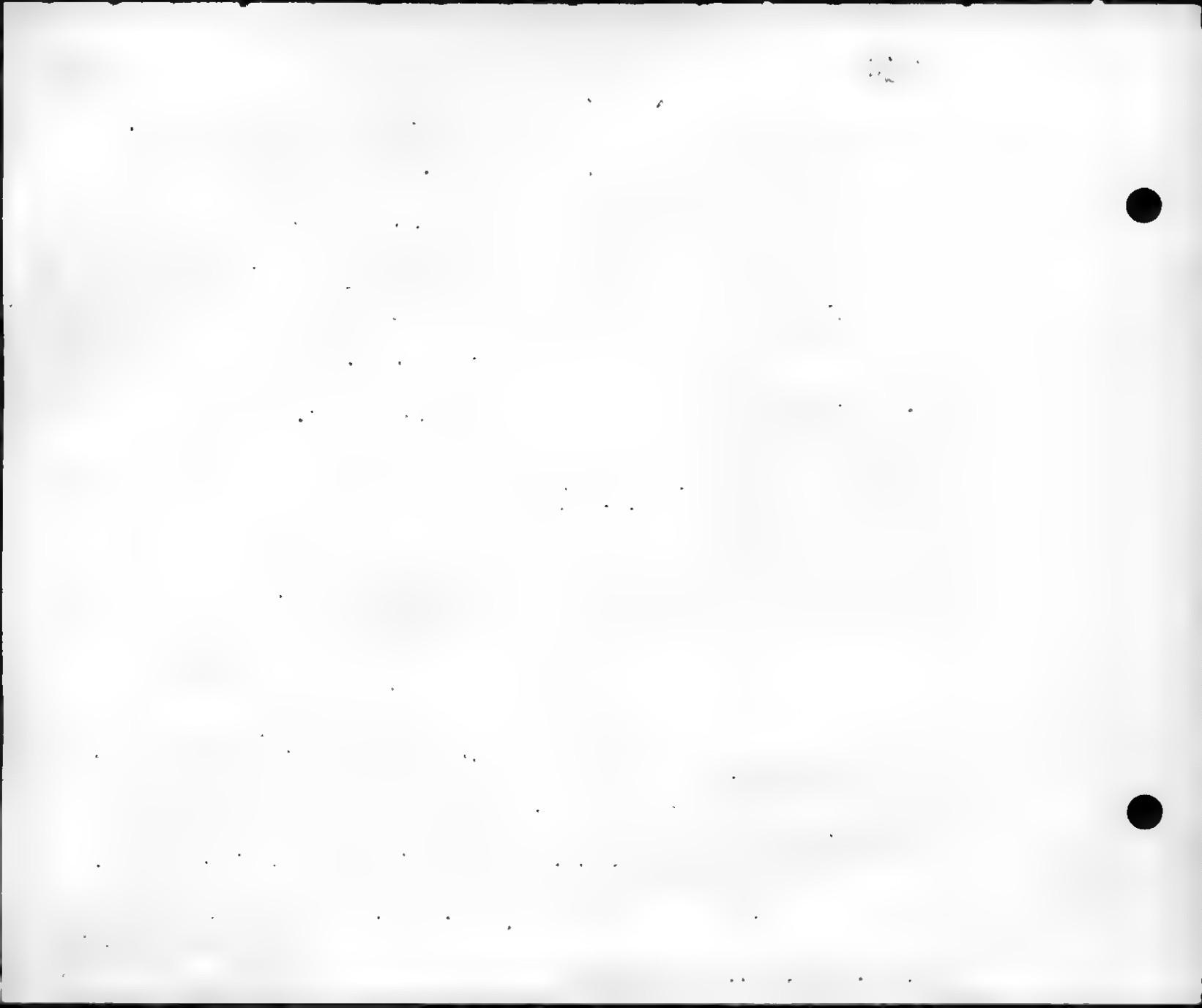
04279		14273																						
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. LENGTH OF STAY IN 1b <b>14 hrs</b>					b. COUNTY <b>Maryland</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Georges</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>					e. STREET ADDRESS <b>Mitchellsville</b>					f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <b>Roosevelt</b>					4. DATE OF DEATH Last <b>Sellman</b>					Month <b>Mar.</b>					Day Year <b>2 1966</b>									
5. SEX <b>Male</b>					6. COLOR OR RACE <b>Negro</b>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>3-16-1923</b>					9. AGE (In years last birthday) <b>44 yrs.</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Henry Sellman Jr.</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Jones</b>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>Estelle Sellman Mitchellville Md.</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b>					DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Post cardiac surgery</b>					DUE TO (b) <b>Post cardiac surgery</b>					DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that <b>He</b> (this hospital) attended the deceased from <b>Mar. 1, 1966</b> , to <b>Mar. 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>Mar. 2, 1966</b> , and that death occurred at <b>5.17 AM</b> from the causes and on the date stated above.					22a. SIGNATURE <b>Edwin J. Jensen</b>					22b. DATE SIGNED <b>3/2/66</b>														
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>					22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly, Md.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>3-5-66</b>					23c. NAME OF CEMETERY OR CREMATORIAL <b>Adams</b>					23d. LOCATION (City, town or county) (State) <b>Towson Md.</b>									
24. FUNERAL DIRECTOR <b>William Reesett</b>					ADDRESS <b>Arnold Rd.</b>					25a. REC'D BY REGISTRAR <b>DAT MAR 4 1966</b>					25b. REGISTRAR'S SIGNATURE <b>John J. Reesett</b>									



**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after the death.

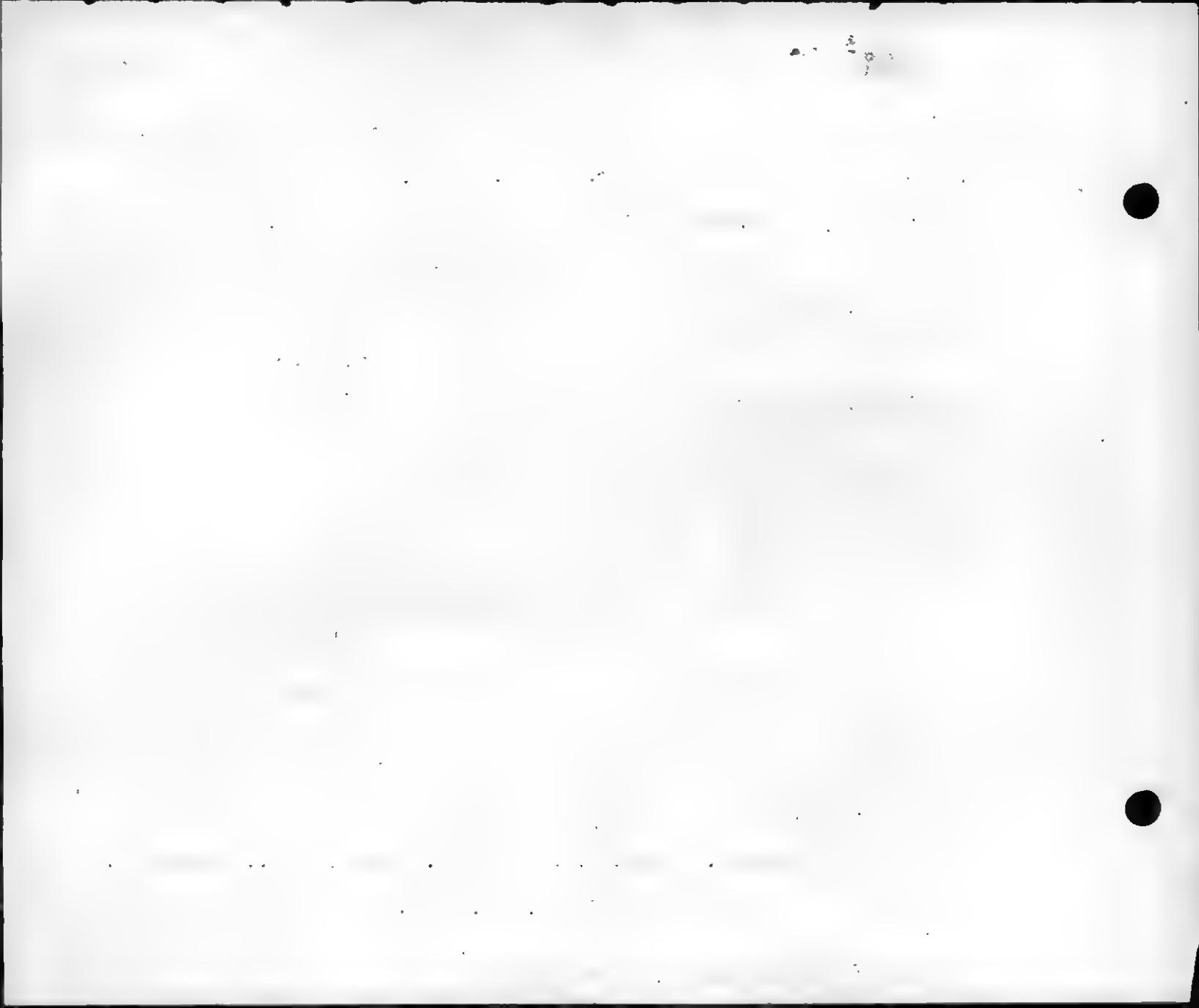
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																					
CERTIFICATE OF DEATH																					
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)																	
a. COUNTY <b>Prince George's</b> MARYLAND				b. STATE Maryland b. COUNTY Anne Arundel																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>																	
c. LENGTH OF STAY IN MD <b>2 hours</b>				d. STREET ADDRESS <b>6 S. Carol Street</b>																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First <b>Baby</b>	Middle <b>Girl</b>	Last <b>Shepard</b>	4. DATE OF DEATH <b>March 28 1966</b>	Month <b>March</b>	Day <b>28</b>	Year <b>1966</b>													
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1966</b>	9. AGE (in years last birthday) <b>yrs.</b>	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS. <b>Days</b>	Hours <b>2</b>	Min. <b>0</b>												
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>William Evans Shepard</b>				14. MOTHER'S MAIDEN NAME <b>Mary Helen Bolton</b>				Address													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>---</b>				17. INFORMANT <b>Mother</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> 7625 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>				20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 28, 1966</b> , to <b>March 28 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 28 1966</b> , and that death occurred at <b>4:55 AM</b> , from the causes and on the date stated above.				22a. SIGNATURE <i>John R. Penn</i>				22b. DATE SIGNED <b>3/28/66</b>				22c. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M.D.</b>				22d. ADDRESS <b>6201 Riverdale Rd. Riverdale, Md.</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				23b. DATE THEREOF <b>4/2/66</b>				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Prince Geo. Gen. Hosp.</b>				23d. LOCATION (City, town or county) <b>Cheverly, Maryland</b>				(State)					
24. FUNERAL DIRECTOR <i>John W. Penn</i>				25a. REC'D BY REGISTRAR <b>APR 7 1966</b>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>													
VR A15 (4) 2DM 1/65																					
Harry W. Penn, Jr., Administrator																					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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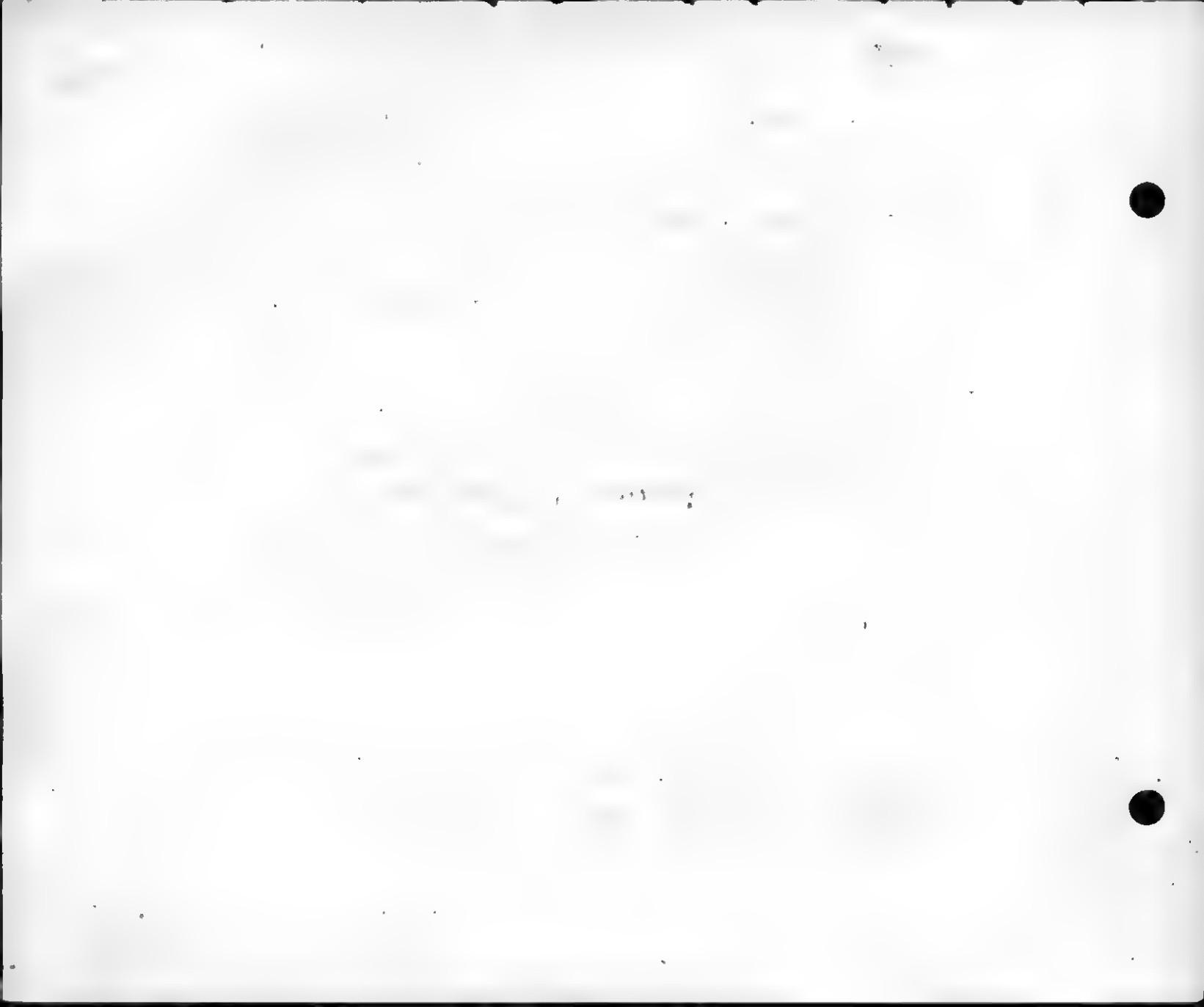
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)								
a. COUNTY <b>Prince Georges</b> MARYLAND				a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>								
c. LENGTH OF STAY IN 1b <b>11 hr. 25 min</b>												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First <b>Baby</b>	Middle <b>Girl "B"</b>	Last <b>Simmons</b>	4. DATE OF DEATH Month <b>March</b>	Month <b>10</b>	Day <b>19</b>	Year <b>66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 9, 1966	9. AGE (in years last birthday) yrs. <b>11</b>	IF UNDER 1 YEAR Months <b>11</b>	IF UNDER 24 HRS. Days <b>25</b>	Hours <b>11</b>	Min. <b>25</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --				11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland USA</b>				12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>William Henry Miller</b>				14. MOTHER'S MAIDEN NAME <b>Susan Jane Simmons</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7625 Bilateral atelectasis</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c)												
INTERVAL BETWEEN ONSET AND DEATH												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>Cheverly</b> (County) <b>Maryland</b> (State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.												
22a. SIGNATURE <b>a G Aronfy</b>												
22b. DATE SIGNED <b>Mar 11 1966</b>												
22c. PHYSICIAN'S NAME (Type) <b>Andrew G. Aronfy, M.D.</b>				ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22d. ADDRESS <b>6803 Good Luck Rd., Lanham, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>3/19/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Prince Geo. Genl Hosp.</b>				23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>				
24. FUNERAL DIRECTOR <b>William A. Parker</b>		ADDRESS <b>William A. Parker, Assist. Administrator</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 22 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Prince Georges MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs, Md</b>						c. LENGTH OF STAY IN 1b <b>152 days</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF Hospital Andrews, Andrews AFB DC</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First <b>ZELL</b>	Middle	Last <b>SKEEN</b>	4. DATE OF DEATH Month <b>March</b>			Day <b>5</b>	Year <b>1966</b>			
5. SEX <b>Fem</b>			6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4 June 1923	9. AGE (in years last birthday) <b>42 yrs.</b>			10. UNDER 1 YEAR Months <b>0</b>	11. UNDER 24 HRS Days <b>0</b>	12. HOURS Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>John Mobley</b>						14. MOTHER'S MAIDEN NAME <b>Ottie Carver</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Andrew V Skeen</b>			Address <b>28B Westover Ave BAFB</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA OF BREAST</b> DUE TO (c) <b>54RS.</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NONE</b>													
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20c. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
					20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								
					21. I certify that <b>(this hospital)</b> attended the deceased from <b>7 Dec 1964</b> to <b>5 March 1966</b> , that we last saw the deceased alive on <b>5 March 1966</b> , and that death occurred at <b>0534</b> , from the causes and on the date stated above.								
		22a. SIGNATURE <b>Donald R. Brade, MD</b>			22b. DATE SIGNED <b>5 March 66</b>								
		22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Burial March 8, 1966</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Goshen Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Jackson Va.</b>					
24. FUNERAL DIRECTOR <b>James S. Eaton</b>		ADDRESS <b>101 Main Street Weston, W. Va.</b>			25a. REC'D BY REGISTRAR <b>DA MAR 17 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



1  
FOR STATE  
HEALTH DEPT.

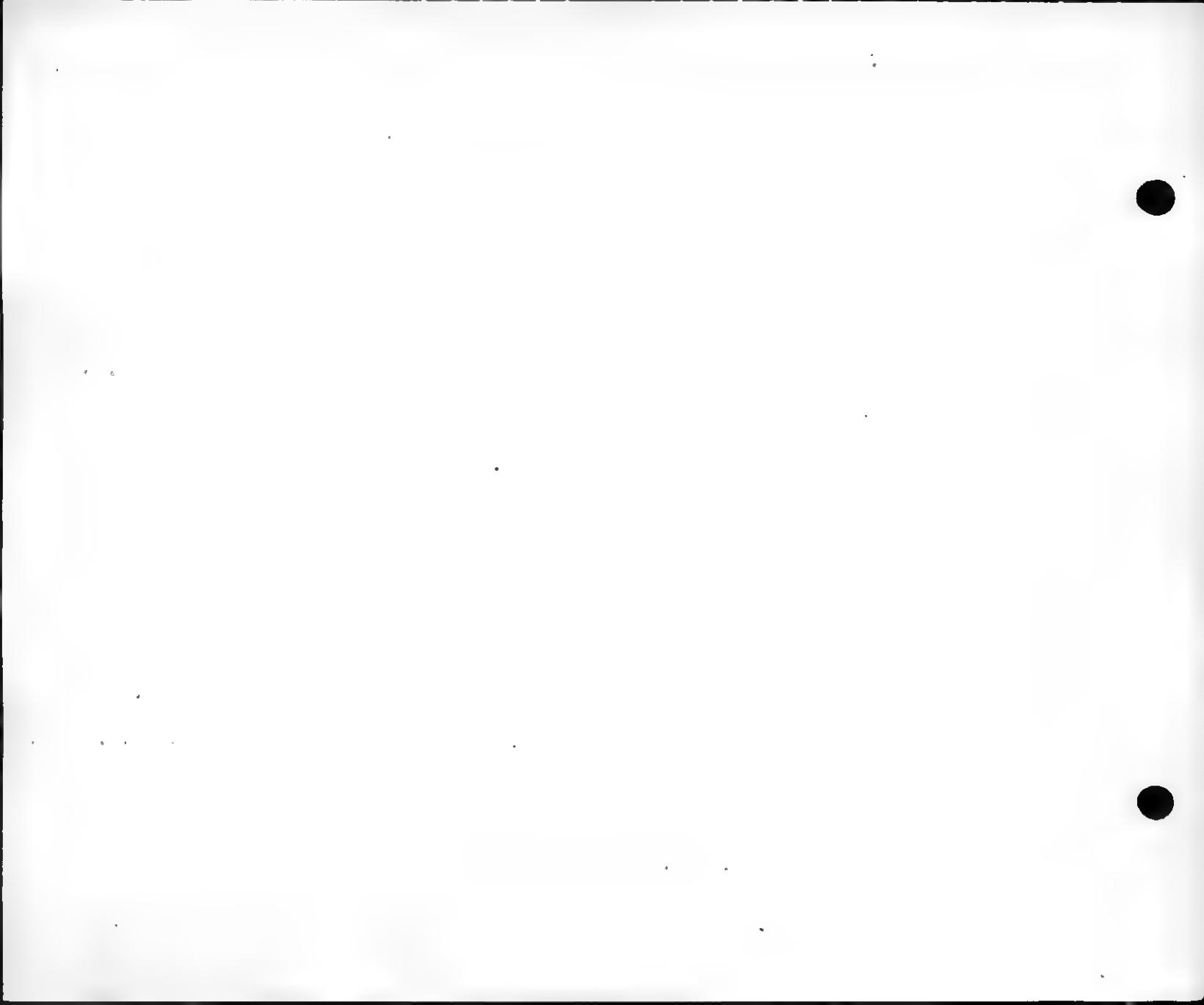
TO **MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if delay is necessary, or execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04288		04277							
1 PLACE OF DEATH a. COUNTY  Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. Prince George							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 703 Sheridan St.							
3 NAME OF DECEASED (Type or print) George Edward Slavin		4 DATE OF DEATH Month Day Year 3 20 19 66							
5 SEX M W		6. COLOR OR RACE 7 MARRIED NEVER MARRIED WIDOWED DIVORCED		8. DATE OF BIRTH 15 May 1933		9. AGE (In years last birthday) 32 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Riverdale, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Horace A. Slavin		14. MOTHER'S MAIDEN NAME Gladys Good		15. INFORMANT Mr. Horace A. Slavin (above address) (Father)		16. SOCIAL SECURITY NO		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock 8234 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause lost. (c) Due to Minutes								INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> Cause of Death		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car which ran off road and hit a pole.		20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:20 p.m. 3 20 19 65 at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 202 near Lottsford Vista Rd., P.G. Md.		20f. (City or Town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 3-20-66		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/66		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		23d. LOCATION (City or Town) Colmar Manor, Md.		25a. REC'D BY REGISTRAR MAR 24 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15ME (5) 6M 1/66									



FOR STATE  
HEALTH DEPT.

delay is  
necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page  
5 may be retained for your files.

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Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
*74*

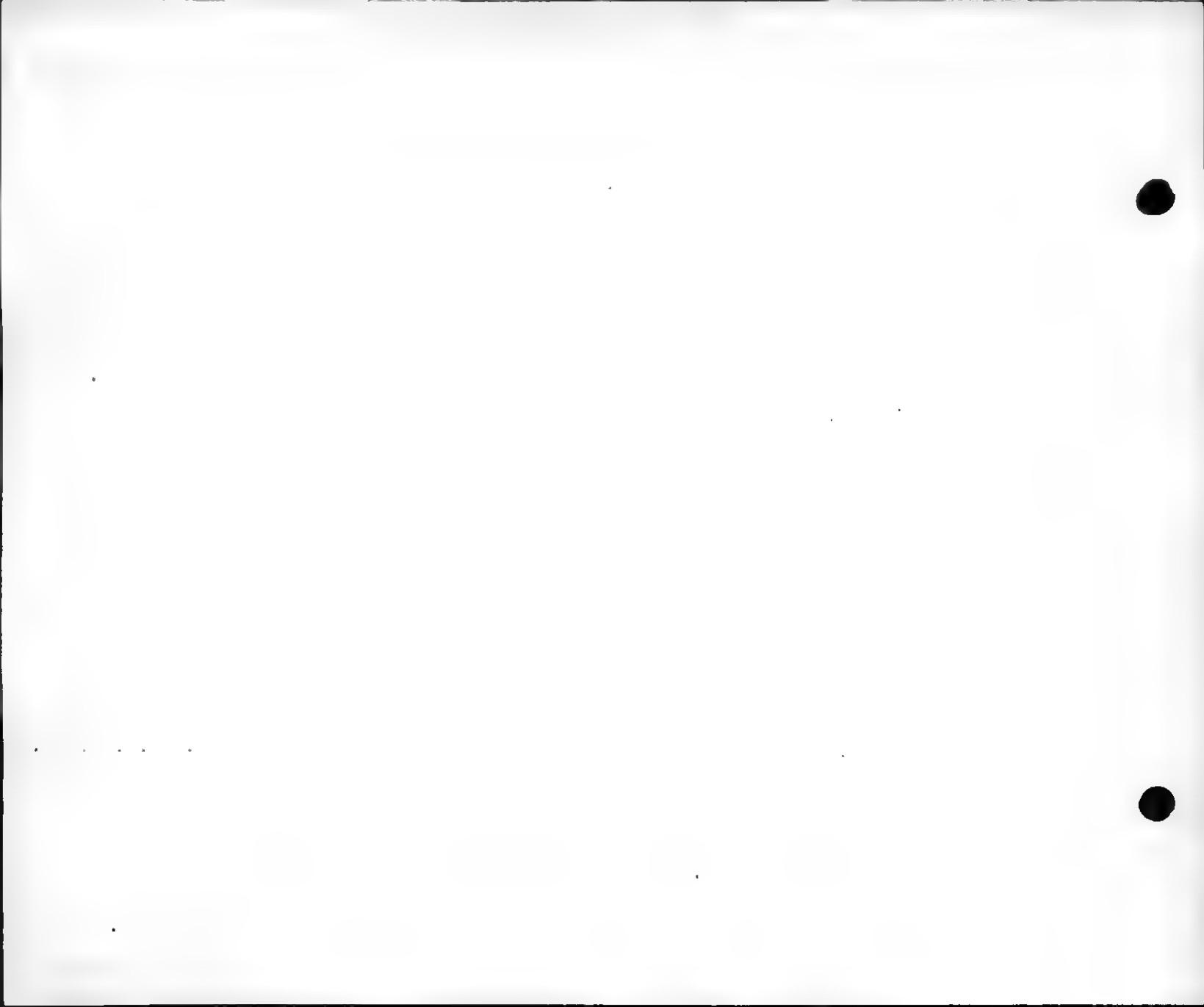
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04278

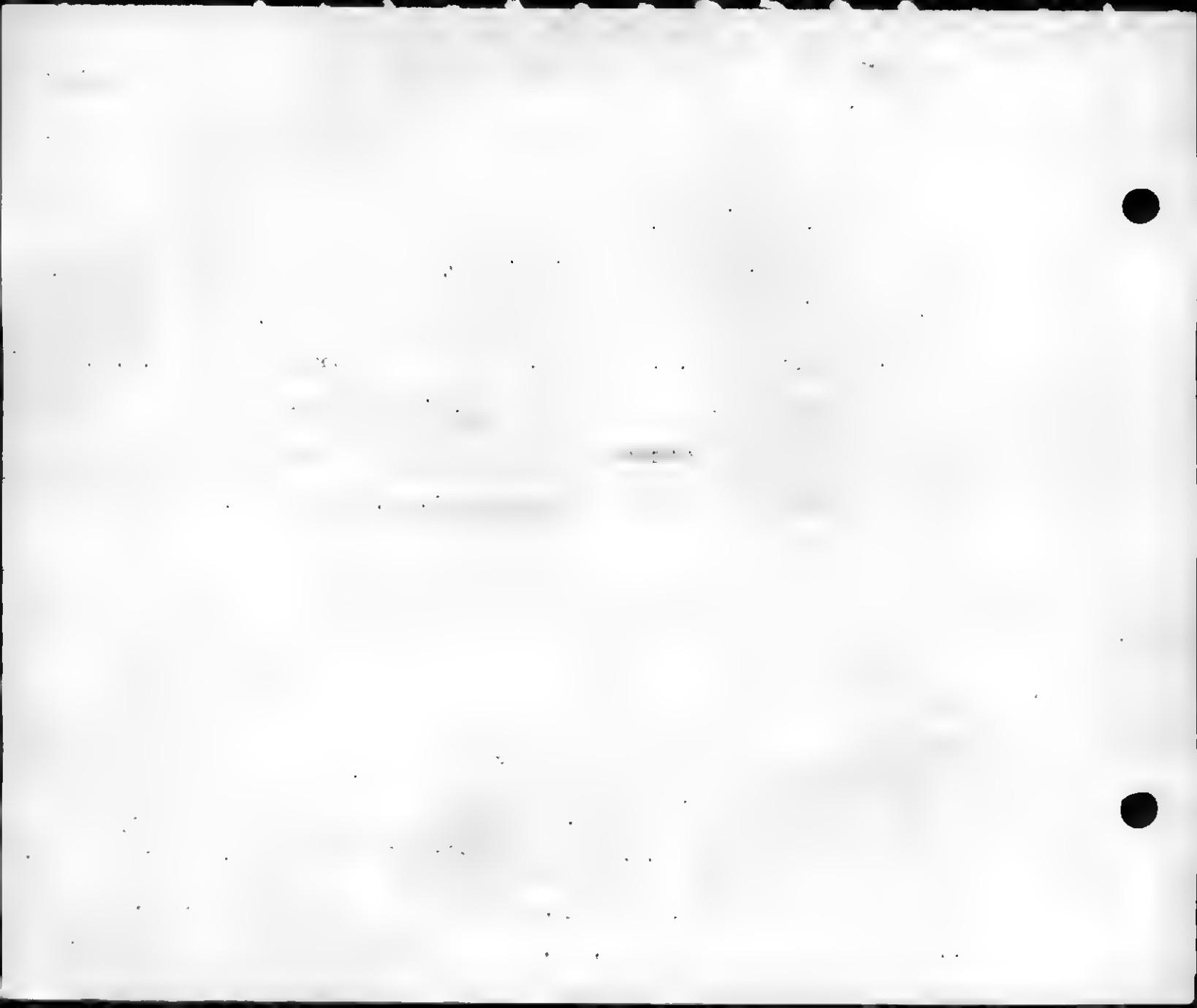
1 PLACE OF DEATH a COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c LENGTH OF STAY IN Tb <b>9 days</b>		c CITY OR TOWN (f out of corporate limits, wrte RURA, and give nearest town) <b>Hyattsville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e STREET ADDRESS <b>703 Sheridan Street</b>	
3 NAME OF DECEASED (Type or print) <b>Gladys Good</b>		First <b>Gladys</b>	Middle <b>Good</b>
4 DATE OF DEATH <b>3 29 1966</b>	Month <b>3</b>	Day <b>29</b>	Year <b>1966</b>
5 SEX <b>Female</b>	6 CO. OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
B DATE OF BIRTH <b>5-29-1913</b>	9 AGE (in years last birthday) <b>52 yrs</b>		IF UNDER 1 YEAR Months <b>0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>	10b KIND OF BUSINESS OR INDUSTRY <b>C. &amp; P. Tele. Co.</b>	11 BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13 FATHER'S NAME <b>George C. Good</b>		
14 MOTHER'S MAIDEN NAME <b>Dora Young</b>		Address	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16 SOCIAL SECURITY NO	17 INFORMANT <b>Mr. Horace A. Slavin (above address)</b>	(Husband)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laceration of brain</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Trauma - Auto accident</b> DUE TO (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Passenger of car which ran off road and hit a pole</b>		20c TIME OF INJURY Month Day Year Hour a.m. <b>5:20pm 3-20-1966</b>	20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Rt. 202 nr. Lottsford Vista Rd., G.C., Md.</b>		20f (City or town) (County) (State) <b>G.C., Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <b>John Kehoe, M.D. Riverdale, Md.</b>	
22. DATE SIGNED <b>3-30-66</b>			
23a BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/1/66</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cem.</b>
23d LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>		23a, RECD BY REGISTRAR <b>APR 4 1966</b>	23b REGISTRAR'S SIGNATURE <i>Charles Judge</i>
24 FUNERAL DIRECTOR ADDRESS <b>Nalley's Funeral Home Inc.</b>		24a FUNERAL DIRECTOR ADDRESS <b>Mt. Rainier, Maryland</b>	24b DATE <b>APR 4 1966</b>



**HOSPITAL**  **ATTENDING PHYSICIAN**  The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1D 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital				d. STREET ADDRESS 4210 GLENDALE DR.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Charlotte P.	Middle Smith	Last Sr.	4. DATE OF DEATH 8-12-66	Month Aug	Day 19	Year 1966						
5. SEX		6. COLOR OR RACE WIDOWED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-04	9. AGE (in years last birthday) 71 yrs.	10. KIND OF BUSINESS OR INDUSTRY Grading Contractor	11. BIRTHPLACE (County & State, or foreign country) Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Charles Pearce Smith	14. MOTHER'S MAIDEN NAME Lula Anderson	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) no	16. SOCIAL SECURITY NO. 578 07 0971	17. INFORMANT Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage right internal capsule OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ OUE TO Underlying cause last. (c) _____														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from 5-2, 1966, to 3-22, 1966, that (I) (we) last saw the deceased alive on 3-26, 1966, and that death occurred at 11 AM, from the causes and on the date stated above.														
22a. SIGNATURE <i>Aaron Deitz</i>				22b. DATE SIGNED 3/23/66										
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.				22d. ADDRESS Prince George's Plaza, Hyattsville, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 25, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln		23d. LOCATION (City, town or county) Holmar Manor, Md.				(State)		
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 28 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



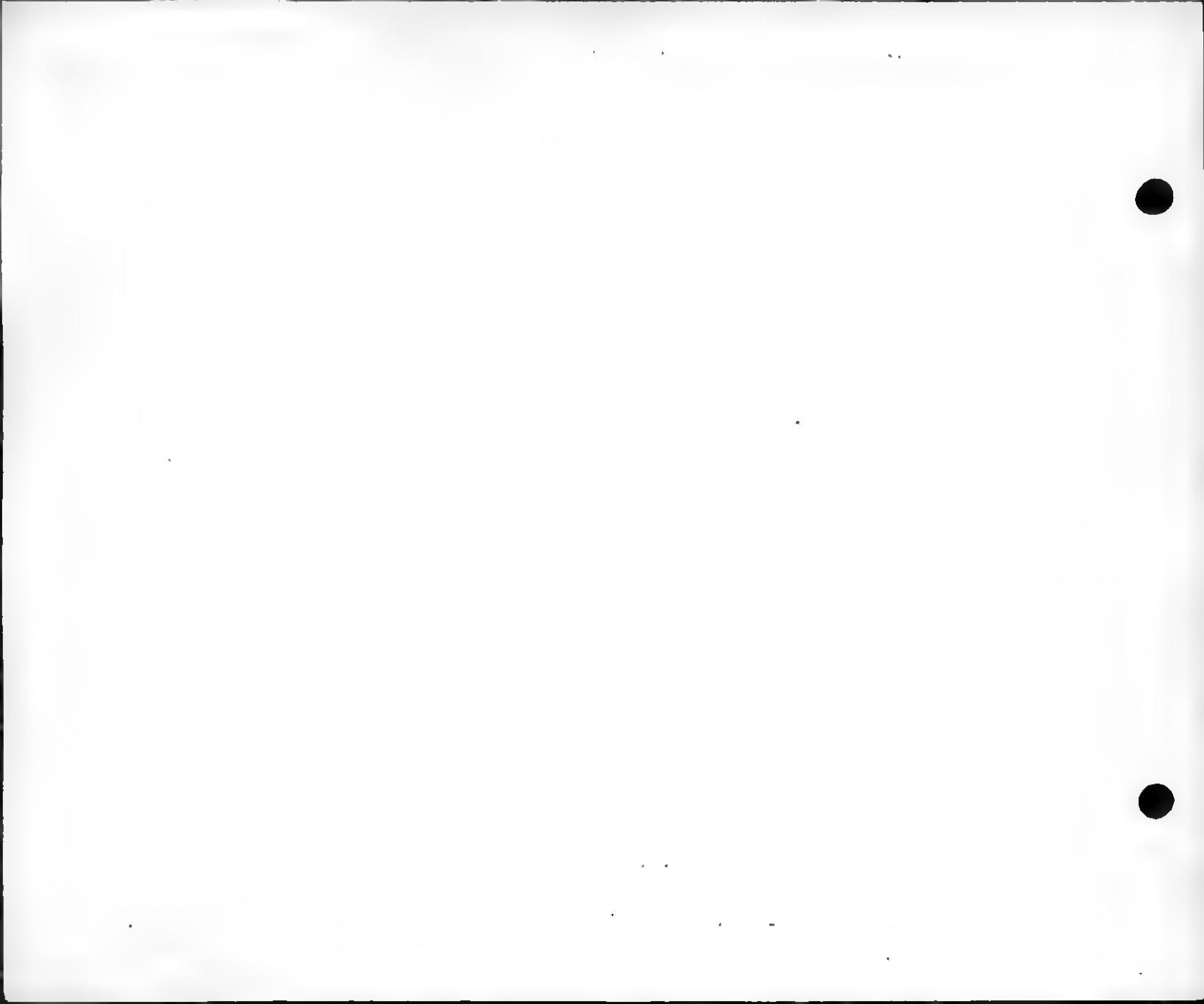
**FOR STATE  
HEALTH DEPT.**

Items 18&20 Film G379 7 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
04286 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
042861

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File copy of page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		c LENGTH OF STAY IN lb <b>Bladensburg</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Ethel Mildred Smith</b>		4 DATE OF DEATH <b>Mar. 24 1966</b>	Month Day Year
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED W-WEDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>14 Dec., 1911</b>
9 AGE (in years lost birthday) <b>54 yrs</b>		10a JESUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>	10b KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert S. Paxton sr</b>		14. MOTHER'S MAIDEN NAME --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO <b>219 34 7998</b>	17. INFORMANT <b>Judith Guice Kentland, Md.</b>
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intoxication</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Overdose of medication (type unknown) <b>hrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Took overdose of medication at home.</b>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Took overdose of medication at home.</b>	
20c TIME OF INJURY Month, Day, Year <b>5:30 p.m. 3/24 1966</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home farm factory, street, office bldg, etc.) <b>Home</b>
		20f (City or town) <b>Bladensburg</b>	(County) (State) <b>P. G. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John F. Chloe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John F. Chloe, M.D., Riverdale</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Mar. 28, 1966</b>	23c NAME OF CEMETERY OR Crematory <b>Ft Lincoln Cemetery</b>
23d LOCATION (City or Town) <b>Colmar Manor, Md.</b>		(County) (State)	
24 FUNERAL DIRECTOR <b>A. Gasch's Sons Hyattsville, Md.</b>		25a ADDRESS <b>ADDRESS</b>	25b RECEIVED BY REGISTRAR DATE <b>MAR 29 1966</b>
		REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

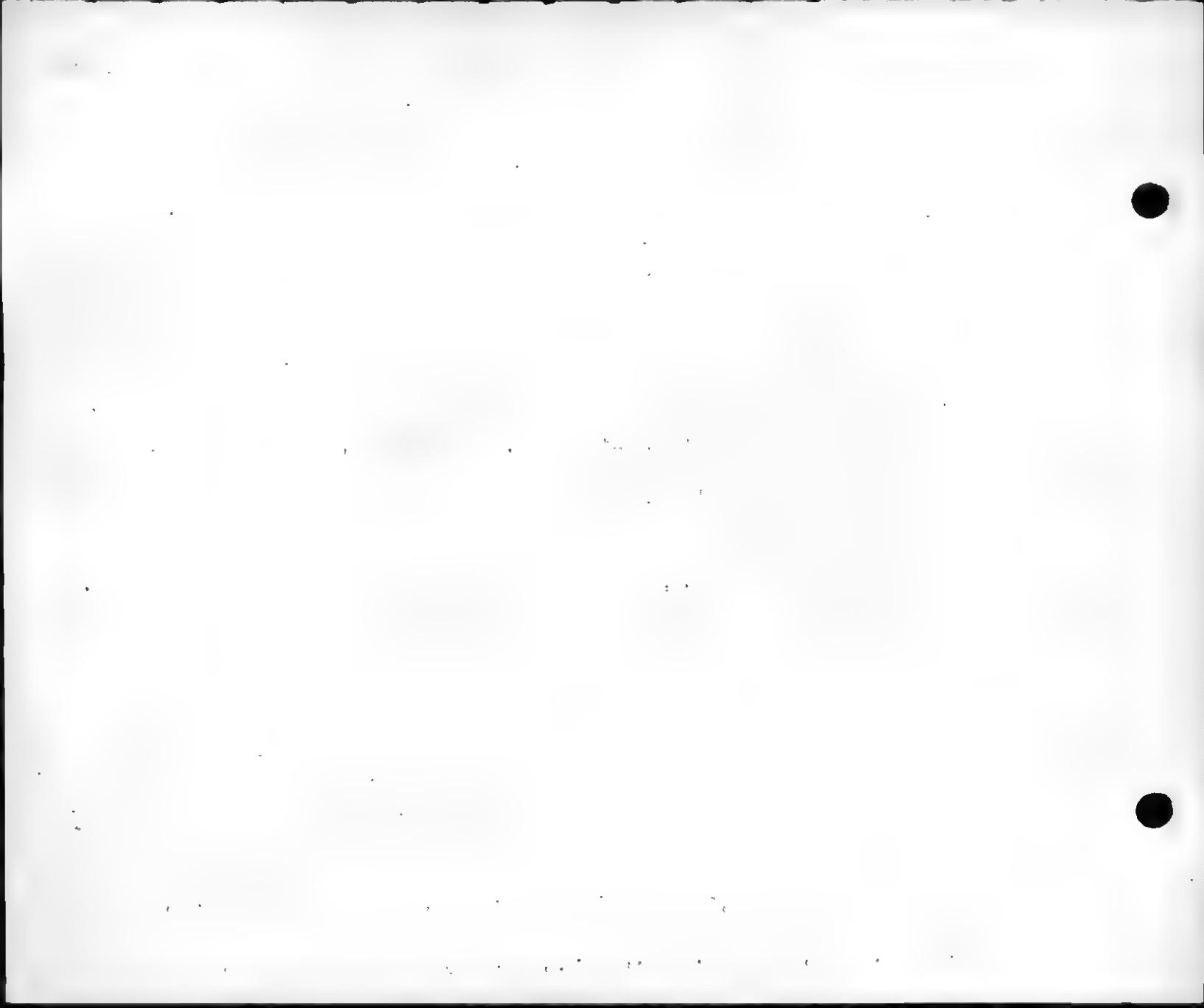


**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that death certificate be executed within 24 hours after death.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)													
a. COUNTY <i>Kinney George</i>				a. STATE <i>Penns.A.</i>													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Philadelphia</i>				c. LENGTH OF STAY IN 1b <i>3 yrs - 3 mos.</i>													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Lain Lianch Nursing Home</i>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Montgomery</i>													
f. STREET ADDRESS <i>73 Johnson Street</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <i>Josephine Russell Solomon</i>				First		Middle		Last		4. DATE OF DEATH <i>3 - 7</i>	Month	Day	Year				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <i>10-29-1896</i>		9. AGE (in years last birthday) <i>69 yrs.</i>		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>White Rose Valley, Pa.</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Andrew Russell</i>				14. MOTHER'S MAIDEN NAME <i>Elvira Schootley</i>				Address									
15. WAS DECEASED EVER IN U.S. ARMEO FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>191-26-1233</i>				17. INFORMANT <i>Mr. Harvey Fabin, Silver Spring Maryland</i>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart attack</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>pneumonia</i> DUE TO (c) <i>Parkinsonism</i>				INTERVAL BETWEEN ONSET AND DEATH <i>9 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>6-25</i>		(County) <i>1966</i>		(State) <i>to 3-7, 1966</i>					
21. I certify that (I) (this hospital) attended the deceased from <i>6-25</i> , 1966, to <i>3-7</i> , 1966, that (I) (we) last saw the deceased alive on <i>3-7</i> , 1966, and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.																	
22a. SIGNATURE <i>M. Snow MD</i>				22b. DATE SIGNED <i>3-7-66</i>													
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>March 10, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>ALLENWOOD CEMETERY,</i>		23d. LOCATION (City, town or county) <i>Allenwood, Pa</i>				(State)					
24. FUNERAL DIRECTOR				ADDRESS <i>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</i>													
				25a. REC'D BY REGISTRAR <i>MAR 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE									



FOR STATE  
M  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

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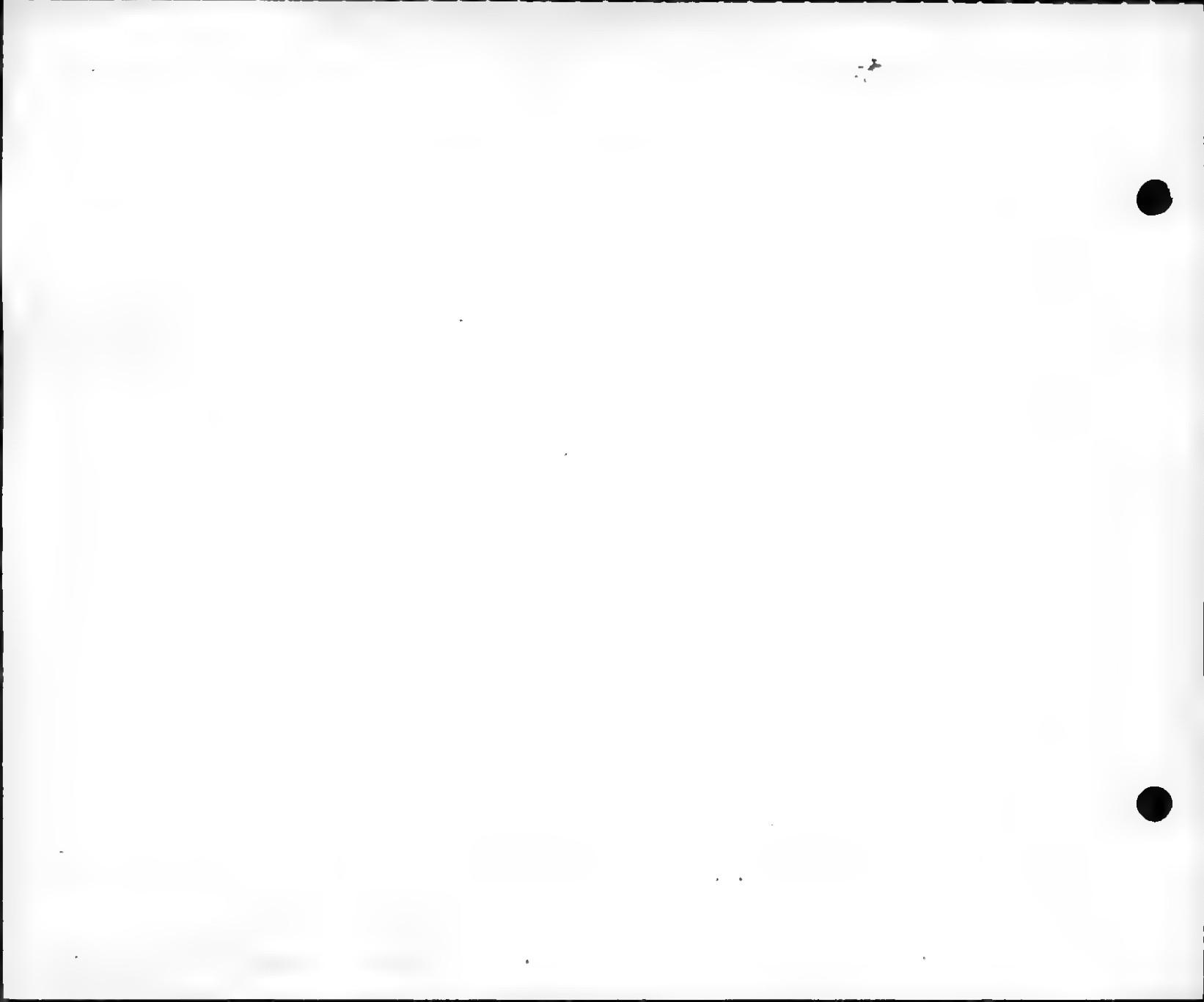
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04288

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04282

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>7415 Ardmore Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>William Courtney Stevenson</b>		First	Middle	Last	4. DATE OF DEATH Month Day Year <b>3 12 1966</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/> <b>NEVER MARRIED</b>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-30</b>	9. AGE (In years last birthday) yrs. <b>35</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
13. FATHER'S NAME <b>Roy Stevenson</b>		14. MOTHER'S Maiden Name <b>Mae Carter</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO <b>1947 to 1931 400 34 4288</b>		17. INFORMANT Address <b>Lillian H Stevenson Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH minutes <b>14270</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c) <b>Arteriosclerotic Heart Disease</b>				over 8 mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>	
23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>					
24. FUNERAL DIRECTOR <b>P. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DA MAR 17 1966	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

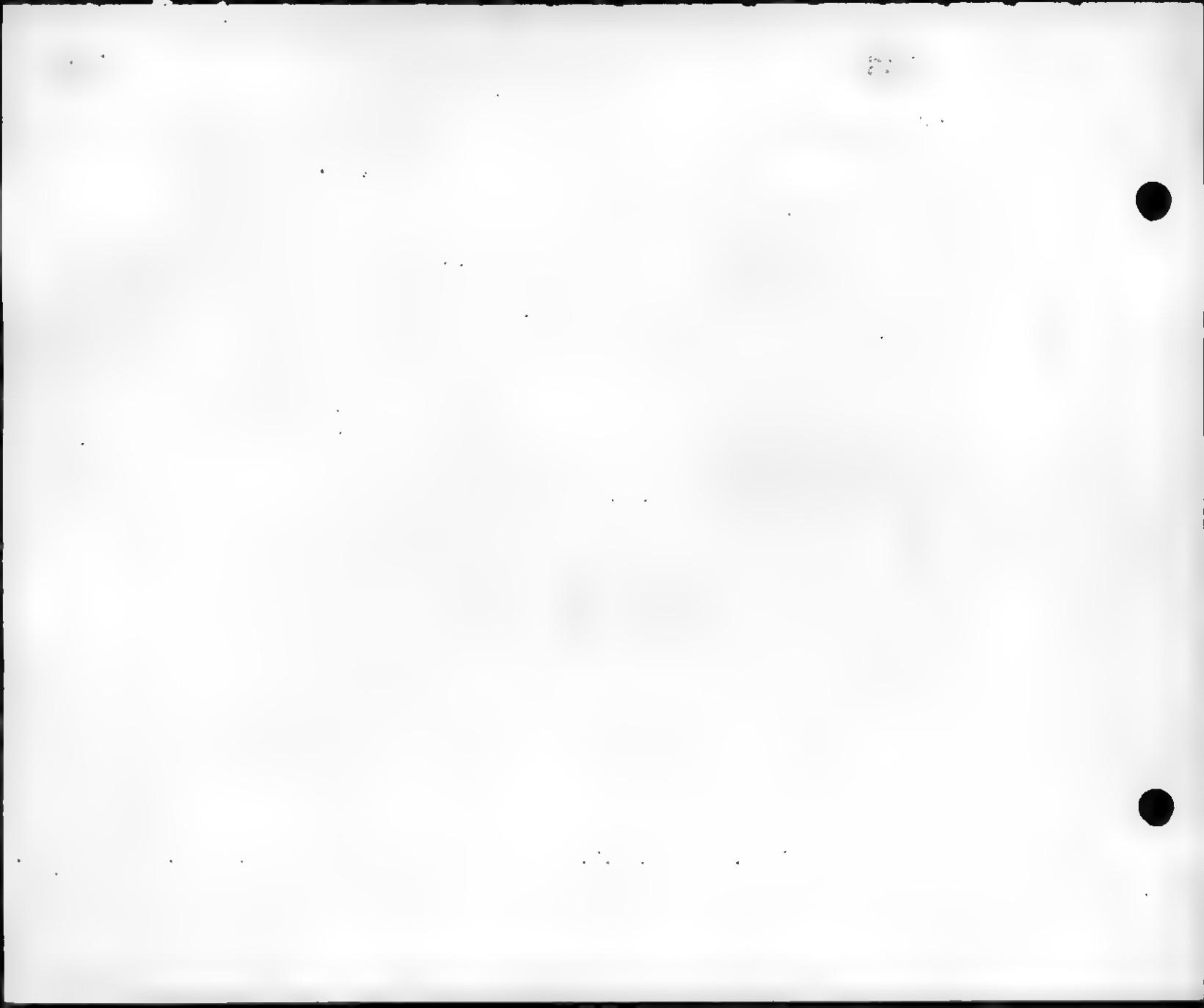


**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #7-Birth 1966											
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
Prince George's MARYLAND		b. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's									
c. LENGTH OF STAY IN 1D 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6737 Roosevelt Avenue									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First Wesley	Middle E	Last Stewart	4. DATE OF DEATH March 11 1966	Month March	Day 11	Year 1966			
5. SEX Male		6. COUNTRY OR RACE White	7. MARRIED WOOED	NEVER MARRIED SEPARATED	8. DATE OF BIRTH 1-16-28	9. AGE (In years last birthday) 38 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofers		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Elmer Stewart		14. MOTHER'S MAIDEN NAME Elaine Childress		Address 3403 Lorain							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Unknown		16. SOCIAL SECURITY NO. 578-28-1813		17. INFORMANT Elaine Stewart Dr. Zonville Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH		
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hepatomegaly									
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Prince George's Genl. Hosp. Cheverly Md.	(County) Baltimore Co.	(State) Md.					
21. I certify that (s) (this hospital) attended the deceased from March 9, 1966, to March 11, 1966, that (s) (we) last saw the deceased alive on March 11, 1966, and that death occurred at 4:30M, from the causes and on the date stated above.		22b. DATE SIGNED 3/11/66									
22a. SIGNATURE Edwin J. Jensen		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince George's Genl. Hosp. Cheverly Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-15-66	23c. NAME OF CEMETERY OR CREMATORIAL Washington National Cemetery		23d. LOCATION (City, town or county) Cheverly Md.		(State) Md.				
24. FUNERAL DIRECTOR W.W. Chambers Jr.		ADDRESS 517-11 E. St. NE.		25a. REC'D BY REGISTRAR MAR 15 1966		25b. REGISTRAR'S SIGNATURE Charles J. G.					
				DATE							

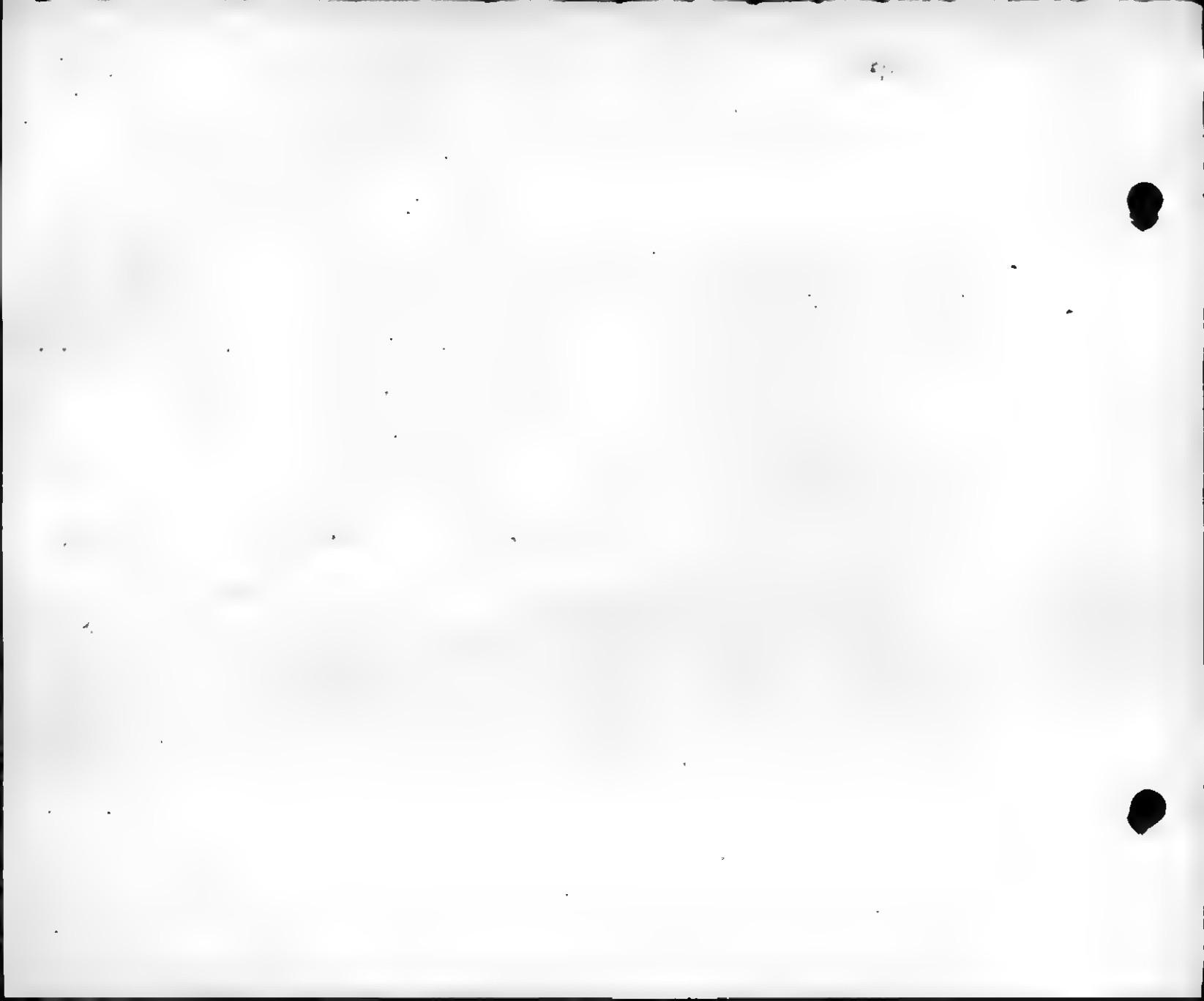


**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
04290 04284															
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				b. COUNTY <b>PRINCE WILLIAMS</b> <b>BROOKE</b>											
c. LENGTH OF STAY IN 1b <b>8 DAYS</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WOODBRIDGE VA</b>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>				d. STREET ADDRESS <b>ELM FARM TRAILER COURT LOT 76</b>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)		First <b>DIANE LYNN STIFT</b>		Middle		Last		4. DATE OF DEATH		Month	Day	Year			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.				
FEMALE		CAU		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		28 DEC 65		yrs. 2 25		Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>				11. BIRTHPLACE (County & State, or foreign country) <b>GRAND FORKS AFB, N.D.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>ROBERT RICHARD STIFT</b>				14. MOTHER'S MAIDEN NAME <b>BETTE JEAN ALLISON</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NA</b>				17. INFORMANT <b>FATHER SAME AS # 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>289 - BRONCHOPNEUMONIA</b>												INTERVAL BETWEEN ONSET AND DEATH <b>11 DAYS</b>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				DUE TO (b) <b>ADULT FIBROSIS</b>				DUE TO (c) <b>CYSTIC FIBROSIS OF PANCREAS</b>				from birth			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>150P M</b>		(County) <b>25 MARCH 1966</b>	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>17 MARCH 1966</b> to <b>25 MARCH 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>25 MARCH 1966</b> , and that death occurred at <b>150P M</b> , from the causes and on the date stated above.															
22a. SIGNATURE <i>Conner W. Moore</i>				22b. DATE SIGNED <b>25 MARCH 1966</b>											
22c. PHYSICIAN'S NAME (Type) <b>CONNER W. MOORE</b>				22d. ADDRESS <b>USAF HOSP ANDREWS AIR FORCE BASE MD</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 3-26-66</b>				23b. DATE THEREOF <b>3-26-66</b>				23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Johns Cemetery Fallsburg West Va</b>				23d. LOCATION (City, town or county) <b>West Va</b>			
24. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>				ADDRESS <b>517-17 SE Washington DC</b>				25a. REC'D BY REGISTRAR <b>DAMAR 28 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



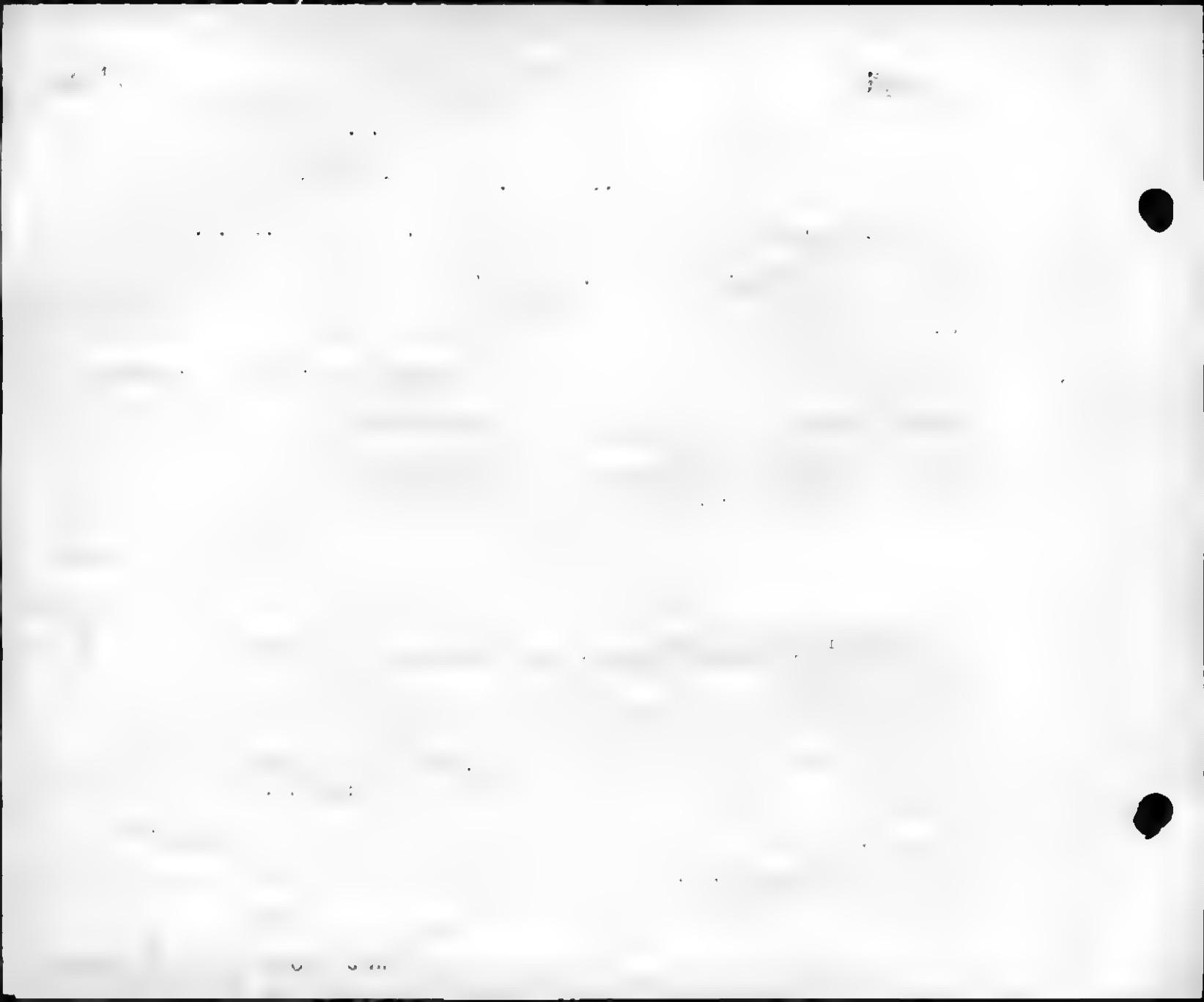
**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) o STATE D.C. b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>	c LENGTH OF STAY IN lb <b>1 mo., 26 dys</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	d STREET ADDRESS <b>427 N. Jersey Ave., S.E.</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William C. Stuerzl</b>	First	Middle	4. DATE OF DEATH <b>March 26 1966</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X	8. DATE OF BIRTH <b>2/14/1904</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steward</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	9. AGE (In years last birthday) <b>62 yrs</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Aurora Pennsylvania</b>
13. FATHER'S NAME <b>Matthew Stuerzl</b>	14. MOTHER'S MAIDEN NAME <b>Rose Stiener</b>	12. CITIZEN OF WHAT COUNTRY? <b>unknown USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>1942-1943</b>	16. SOCIAL SECURITY NO <b>unknown</b>	17. INFORMANT <b>decedent</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>acute pyelonephritis left kidney with uremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <b>451X</b>		DUE TO <b>left ureteral obstruction due to left peri-prosthetic abscess</b>	unknown
		DUE TO <b>Teflon prosthetic replacement of terminal aorta</b>	
		DUE TO <b>("Y" graft) for lumbar aortic aneurysm</b>	8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>bronchopneumonia; coronary atherosclerosis with old posterior myocardial infarction and congestive heart failure</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</b>		
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>Jan. 28 1966</b> , to <b>March 26 1966</b> , that <b>(s)</b> (we) lost saw the deceased alive on <b>March 26 1966</b> , and that death occurred at <b>3:20 P.M.</b> causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>	22d. ADDRESS <b>Glenn Dale Hospital</b> <b>Glenn Dale, Maryland</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>3/30/66</b>	23b. DATE THEREOF <b>3/30/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR <b>James T Ryan 317-PENN, 146SE</b>	ADDRESS <b>317-PENN, 146SE</b>	25a. REC'D BY REGISTRAR <b>MAR 30 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

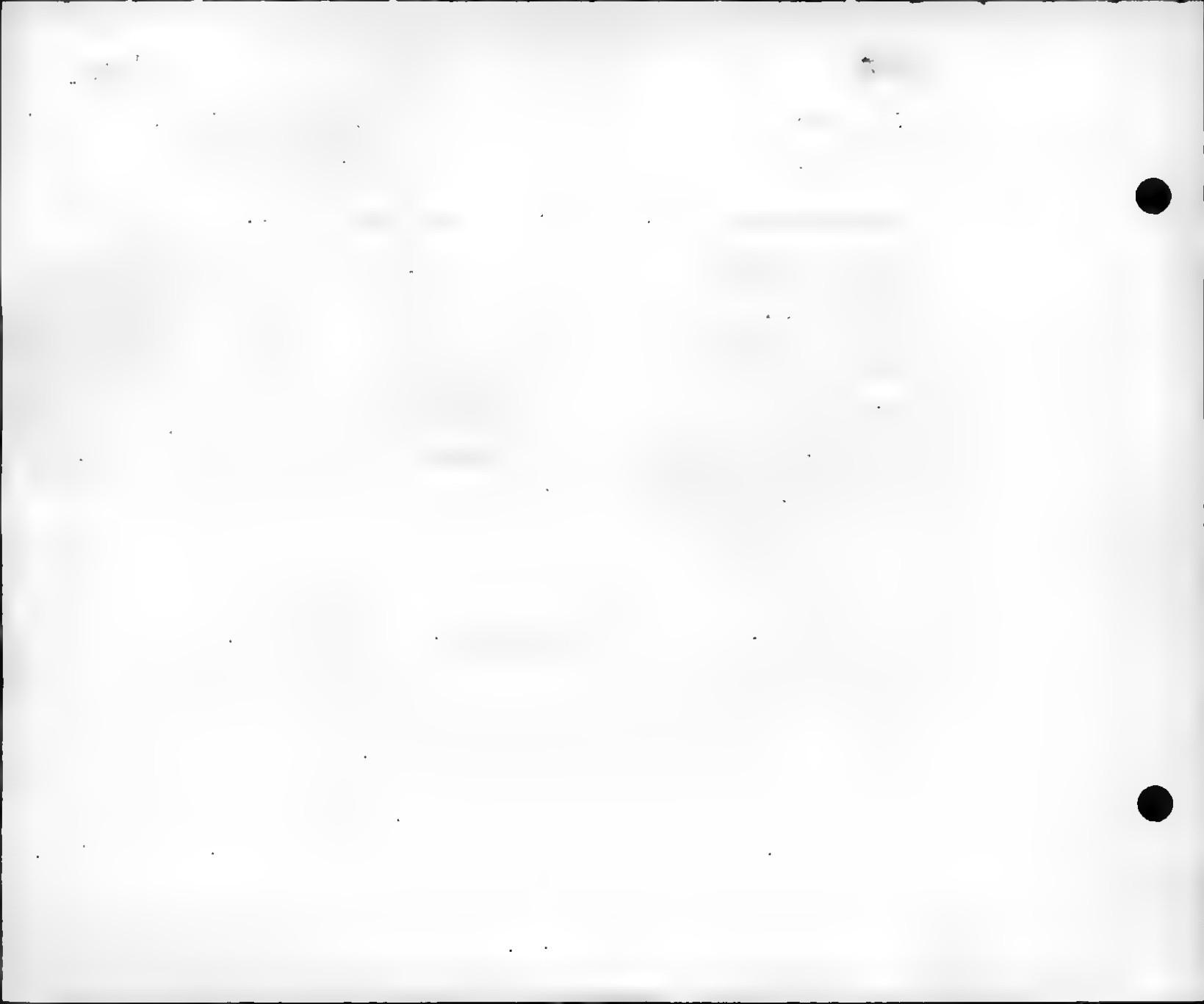


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1 M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <b>Prince George's</b>				a. STATE <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>				b. COUNTY <b>Prince George's</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>									
3. NAME OF DECEASED (Type or print) <b>Sam</b>				4. DATE OF DEATH <b>March 11 1966</b>				d. STREET ADDRESS <b>5259 OAK CREST RD.</b>					
5. SEX <b>Male</b>				6. COLOR OR RACE <b>Cauc.</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPPLY CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>				8. DATE OF BIRTH <b>9-12-10</b>					
13. FATHER'S NAME <b>JOSEPH SWERDLOFF</b>				9. AGE (in years last birthday) <b>55 yrs.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>WISCONSIN</b>					
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>890-07-7188</b>				17. INFORMANT <b>JEAN SWERDLOFF</b>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Diverticulitis &amp; Hemorrhage</b>				Address <b>5259-OAK CREST DR OXON HILL MD</b>				INTERVAL BETWEEN ONSET AND DEATH					
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>410</b> (b) (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Such as</b>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>I developed a condition (B) fest.</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>7:30 P</b>		(County) <b>3/12/66</b>		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-15</b> , 19 <b>66</b> , to <b>3-11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-11</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Leo N. Mugmon</b>				22b. DATE SIGNED <b>3/12/66</b>									
22c. PHYSICIAN'S NAME (Type) <b>Leo N. Mugmon, M.D.</b>				22d. ADDRESS <b>2711 GAITHER ST. HILLCREST HARBOUR, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>3/13/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>GEORGE WASH CEM.</b>		23d. LOCATION (City, town or county) <b>HATTSVILLE MD</b>		(State)			
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>				ADDRESS <b>4217-9th St. N.W.</b>		25a. REC'D BY REGISTRAR <b>DATE</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File Page 4 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04293

04287

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Prince George's		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if inst llt or Residence before admission) a STATE Maryland	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton		c LENGTH OF STAY IN lb Doa		c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Southern Maryland Hospital		d STREET ADDRESS 7504 Mansfield Drive		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First John	Middle James	Last Taylor	4 DATE OF DEATH 3	Month 3 Year 1966
5 SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-4-16	9 AGE (in years lost birthday) 49 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b KIND OF BUSINESS OR INDUSTRY Automobile		11 BIRTHPLACE (State or foreign country) Virginia	
13 FATHER'S NAME John Taylor		14. MOTHER'S MAIDEN NAME Pearl Hall		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1943-1945		16 SOCIAL SECURITY NO. - - -		17 INFORMANT Martha Taylor (Wife) See Item #2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Heart Failure			
4 10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) Hypertension (c) Arteriosclerotic Heart Disease			
		INTERVAL BETWEEN ONSET AND DEATH over 2 years			
20c EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)	
20f (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Keloe</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Keloe M.D., Riverdale, Maryland				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 3-3-66					
23a BURIAL, CREMATION Burial		23b DATE THEREOF 3-8-1966		23c NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l. Cem.	
23d LOCATION (City or Town) Arlington, Va.		(County) (State)			
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. NW Washington, D.C.		ADDRESS		25a RECEIVED BY REGISTRAR MAR 9 1966	
				25b REGISTRAR'S SIGNATURE <i>Marley Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 9, 11, 14, 11, m, 6, 7, 8, 4/4/66FOR STATE  
HEALTH DEPT.

**TO DUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

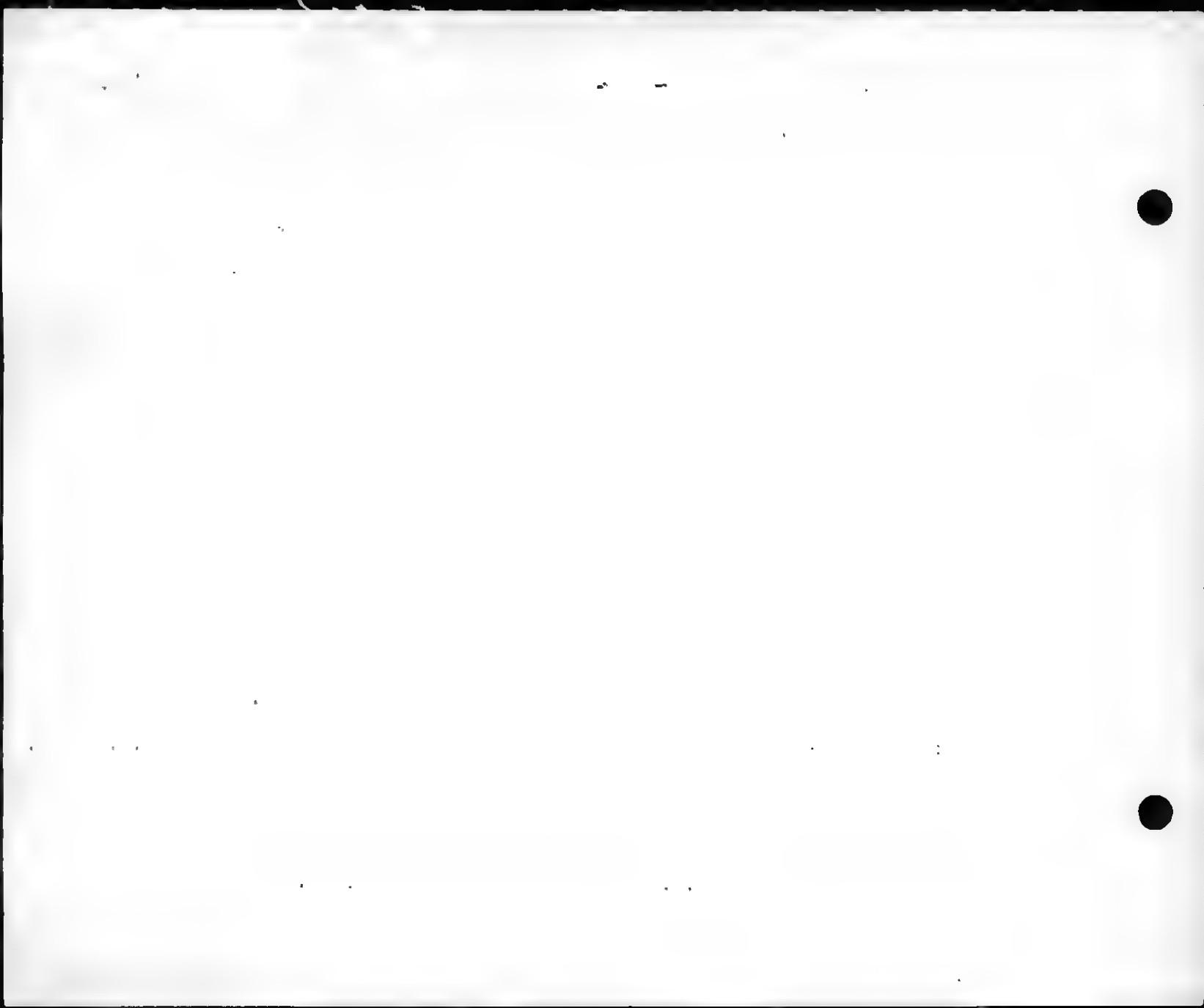
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04294

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04288

PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission)	
a COUNTY Prince George's MARYLAND		a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	c LENGTH OF STAY IN lb	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1521 Banner Street		d STREET ADDRESS 1521 Banner Street e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle Thomas		4 DATE OF DEATH Month March Day 8 Year 1966	
5 SEX male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	8 DATE OF BIRTH 11-16-89 7
9 AGE (In years as of birthday) 69 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a JUSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTH PLACE (State or foreign country) Unknown		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16 SOCIA. SECURITY NO	
17 INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause (b) Inhalation of smoke DUE TO last (c)		INTERVAL BETWEEN ONSET AND DEATH minutes minutes	
PART II OTHER CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Trapped in upstairs room by house fire.	
20c TIME OF INJURY Month, Day, Year 3:00PM p.m. March 8 1966		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) House
20f (City or town) Brentwood		(County) P.G.	
(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>J. Kehoe, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) John Kehoe, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Registrar (Title, town or county) Charles Judge	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 13-14-66	
23c NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery		23d LOCATION (City or town) Arlington, Va. (County) (State)	
24 FUNERAL DIRECTOR Brown & Dawson 5635 Eads		ADDRESS	
25a REC'D BY REGISTRAR D MAR 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

M

04295

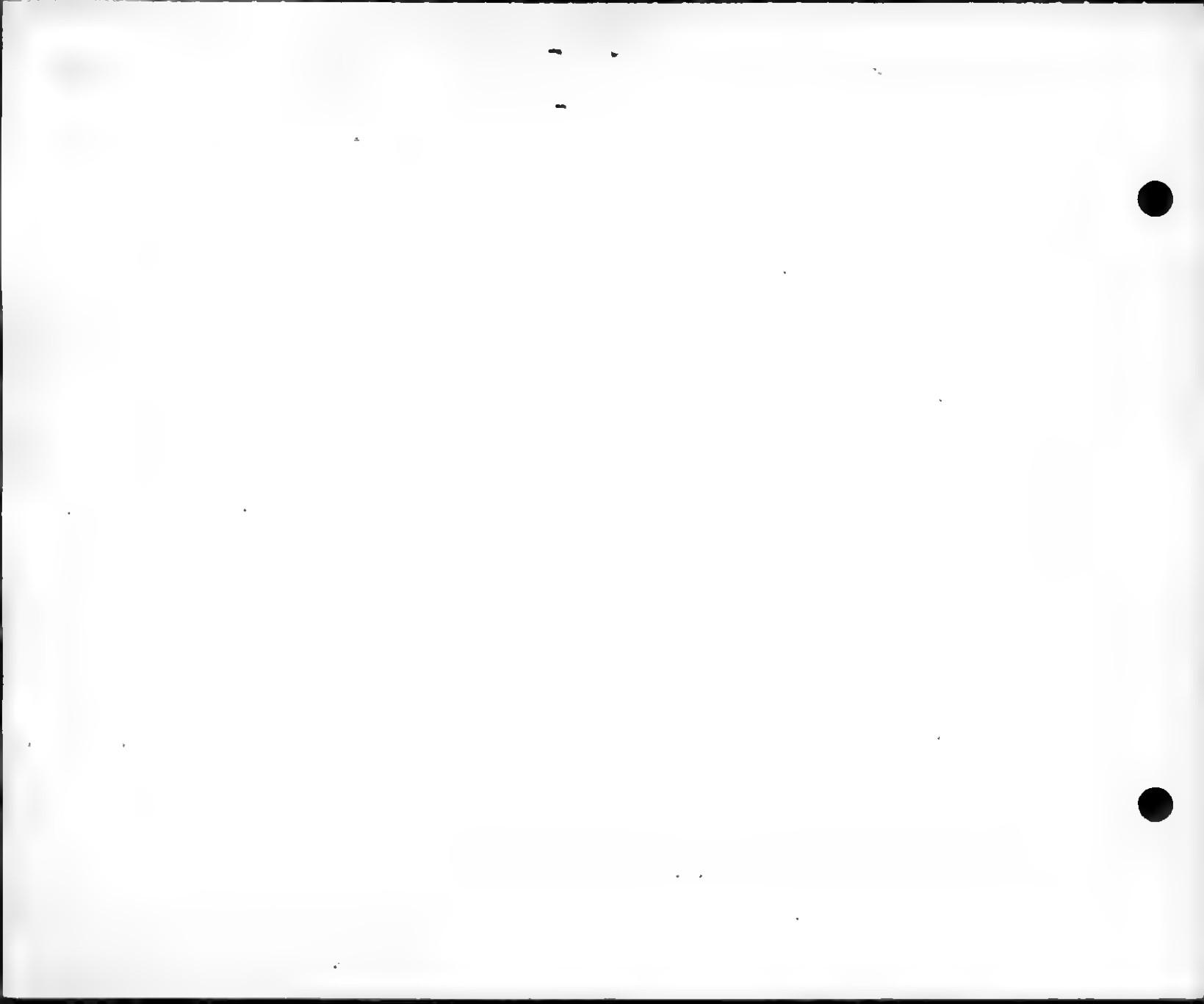
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04289

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY  Prince George's		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Brentwood		c. LENGTH OF STAY IN lb  60	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  4521 Banner Street		e. STREET ADDRESS  4521 Banner Street	
3. NAME OF DECEASED (Type or print)  First James William Thompson		4 DATE OF DEATH  March 8 1966	
S. SEX male	6 COLOR OR RACE Negro	7 MARRIED W DIVORCED	8 NEVER MARRIED DOWED
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired)  Veteran		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)  Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?  U.S.	
13. FATHER'S NAME  George Franklin		14. MOTHER'S MARRIED NAME  Ella Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or date of service)  Never served		16. SOCIAL SECURITY NO  217-14-7754	
17. INFORMANT  Mrs. Ella Thompson		18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Asphyxiation	
DUE TO (b) Cord knots if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH MINUTES  minutes	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)  Trapped in upstairs room by house fire.	
20c. TIME OF INJURY Month Day Year 3:00 P.M. 8 March 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House
		20f. (City or town) Brentwood	(Country) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address: Rivendale, Md. (County)	
23a. BURIAL/CREMATION, REMOVAL (Specify) 3/14/66		23b. DATE THEREOF 3/14/66	
23c. NAME OF CEMETERY OR CREMATORIAL Facility Arlington National Cemetery, Arlington, V.A.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Brown & Cawthon		ADDRESS 5635 - East St NE	25a. REC'D BY REGISTRAR MAR 28 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04296		04290	
<p>1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LANHAM</i></p> <p>c. LENGTH OF STAY IN 1b <i>2 mos</i></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>MAGNOLIA GARDEN'S Nursing Home</i></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i></p> <p>b. COUNTY <i>Prince Georges</i></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HYATTSVILLE</i></p> <p>d. STREET ADDRESS <i>5612 HAMILTON MANOR Dr.</i></p>	
<p>3. NAME OF DECEASED (Type or print) <i>MARY H. Thompson</i></p> <p>First      Middle      Last</p>		<p>4. DATE DEATH <i>MARCH 4 1966</i></p>	
<p>5. SEX <i>FEMALE</i></p> <p>6. COLOR OR RACE <i>white</i></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>Aug 29 1864</i></p> <p>9. AGE (In years last birthday) <i>101 yrs.</i></p> <p>10. IF UNDER 1 YEAR Months    Days    Hours    Min. 11. IF UNDER 24 HRS</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i></p>		<p>12. BIRTHPLACE (County &amp; State, or foreign country) <i>Ireland</i></p> <p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>13. FATHER'S NAME <i>Michael McLoughlin</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Catherine Kelly</i></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>NONE</i></p>	
<p>17. INFORMANT <i>Grace M. Fallon Same As #2 (daughter)</i></p>		<p>Address</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEART FAILURE</i></p> <p>DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i></p> <p>Generalized Arteriosclerosis 10 yrs</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>			
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i></p>
<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <i>JUNE 1960</i> to <i>3/4 1966</i>, that (I) (we) last saw the deceased alive on <i>3/4 1966</i>, and that death occurred at <i>1172 M</i>, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <i>Norman X. O'meara</i></p>		<p>22b. DATE SIGNED <i>3/4/66</i></p>	
<p>22c. PHYSICIAN'S NAME (Type) <i>Norman X. O'meara</i></p>		<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>23b. DATE THEREOF <i>3/7/66</i></p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Olivet</i></p>		<p>23d. LOCATION (City, town or county) (State) <i>WASHINGTON DC</i></p>	
<p>24. FUNERAL DIRECTOR <i>J. J. Darsch's Sons Hyattsville, Md.</i></p>		<p>ADDRESS <i>1177 16th Street, Hyattsville, Md.</i></p>	
<p>25a. REC'D BY REGISTRAR</p>		<p>25b. REGISTRAR'S SIGNATURE</p>	



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MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## **CERTIFICATE OF DEATH**

04291

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b> Pr. Geo.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Geo. Gen. Hospital</b>				d. STREET ADDRESS <b>6636 - Adran St.</b>		e. DATE OF DEATH Month Day Year <b>March 17 1966</b>							
3. NAME OF DECEASED (Type or print) <b>Clyde</b>		First <b>F.</b>	Middle <b>Throne</b>	Last <b>Throne</b>	4. DATE OF DEATH Month Day Year <b>March 17 1966</b>	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/1912</b>	9. AGE (in years last birthday) <b>53 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Curtis L. Throne</b>				14. MOTHER'S MAIDEN NAME <b>Anna Staley</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>175-10-7077</b>				17. INFORMANT Address <b>Mrs. Lorraine Throne (above address)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>					
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Rheumatic Heart Disease</b>								(c) <b>Years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary Emphysema</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>3-2-</b> , 19 <b>66</b> , to <b>3-16-1966</b> , that (I) (we) last saw the deceased alive on <b>3-16-1966</b> , and that death occurred at <b>3-16-1966</b> from the causes and on the date stated above.								22b. DATE SIGNED					
22a. SIGNATURE <b>Angus W. McLaughlin</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <b>Angus W. McLaughlin</b>				22d. ADDRESS <b>3415 Hamilton St.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/19/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Fort Lincoln Cem. Mt. Rainier Maryland</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>							
24. FUNERAL DIRECTOR <b>Valley's Funeral Home Inc.</b>				25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

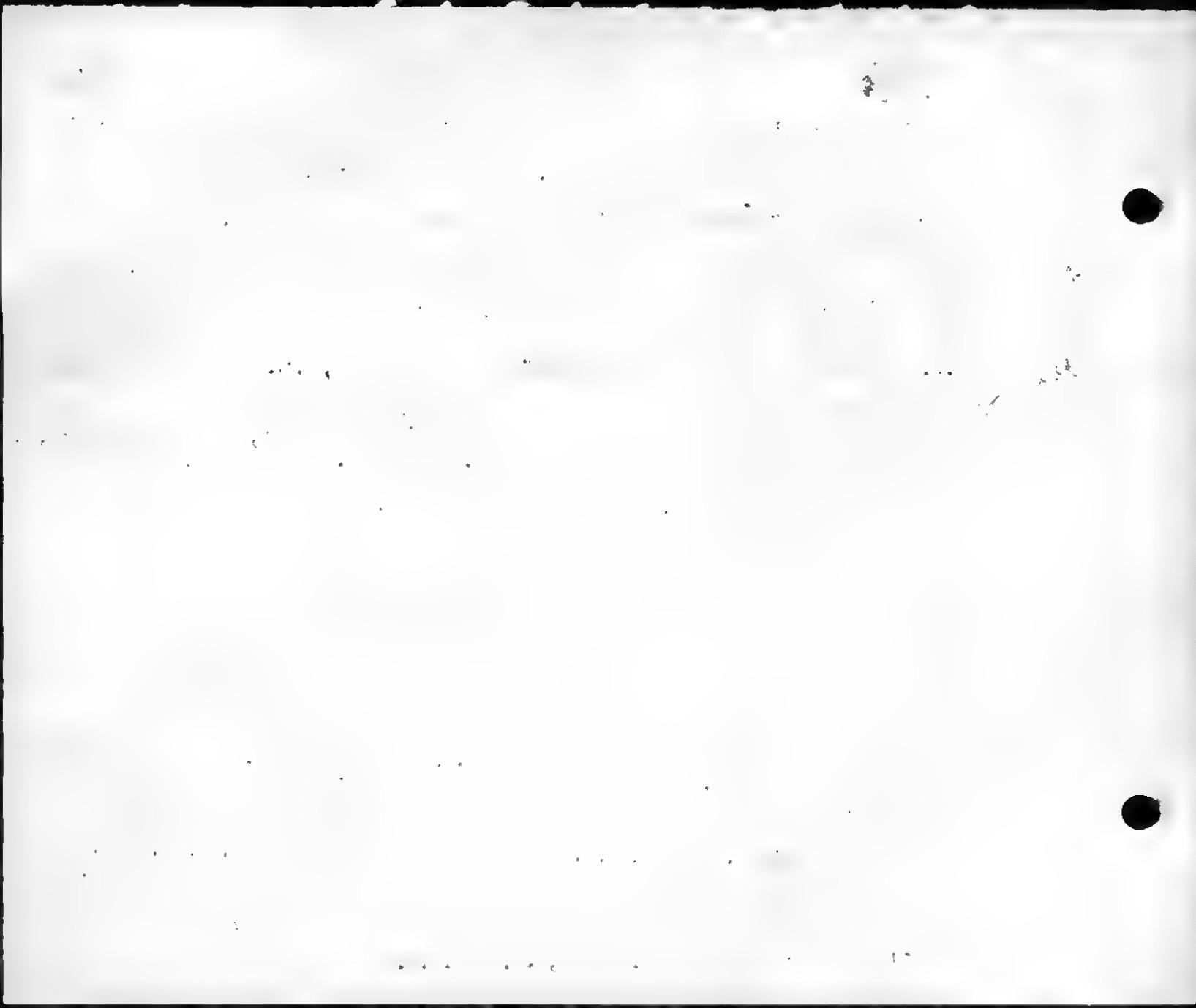


**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <b>Prince George's</b>			a. STATE <b>Maryland</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			b. COUNTY <b>Prince George's</b>									
c. LENGTH OF STAY IN 1b <b>7-1/2 hrs.</b>												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Joseph L. Thume</b>			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-25-07</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>D.C. FIREMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>FIRE DEPARTMENT</b>			11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
13. FATHER'S NAME <b>JOSEPH THUME</b>			14. MOTHER'S MAIDEN NAME <b>ALYSE HEARTCASTLE</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>			16. SOCIAL SECURITY NO. <b>17. INFIRMITY (Wife) Address MRS. LILLIE V. THUME 14042 Willoughby</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Profound - bilateral</i>												
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i> </i>												
DUE TO (c) <i> </i>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Mar. 1, 1966</b>	(County) <b>Upper Marlboro, Md</b>	(State) <b> </b>					
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 1, 1966</b> , to <b>Mar. 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Mar. 1, 1966</b> , and that death occurred at <b>8:00</b> from the causes and on the date stated above.												
22a. SIGNATURE <i>Edwin J. Jensen</i>			22b. DATE SIGNED <b>3/2/66</b>									
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>			22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/5/1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>CEDAR HILL CEMETERY</b>								
24. FUNERAL DIRECTOR <b>Kerry E. Hysong</b>			25a. REC'D BY REGISTRAR <b>SUTTLEND, MARYLAND</b>									
HYSONG'S FUNERAL HOME 1300 N. STREET, N.W. WASH. D.C.			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PN3. Page 5 may be retained for your files.

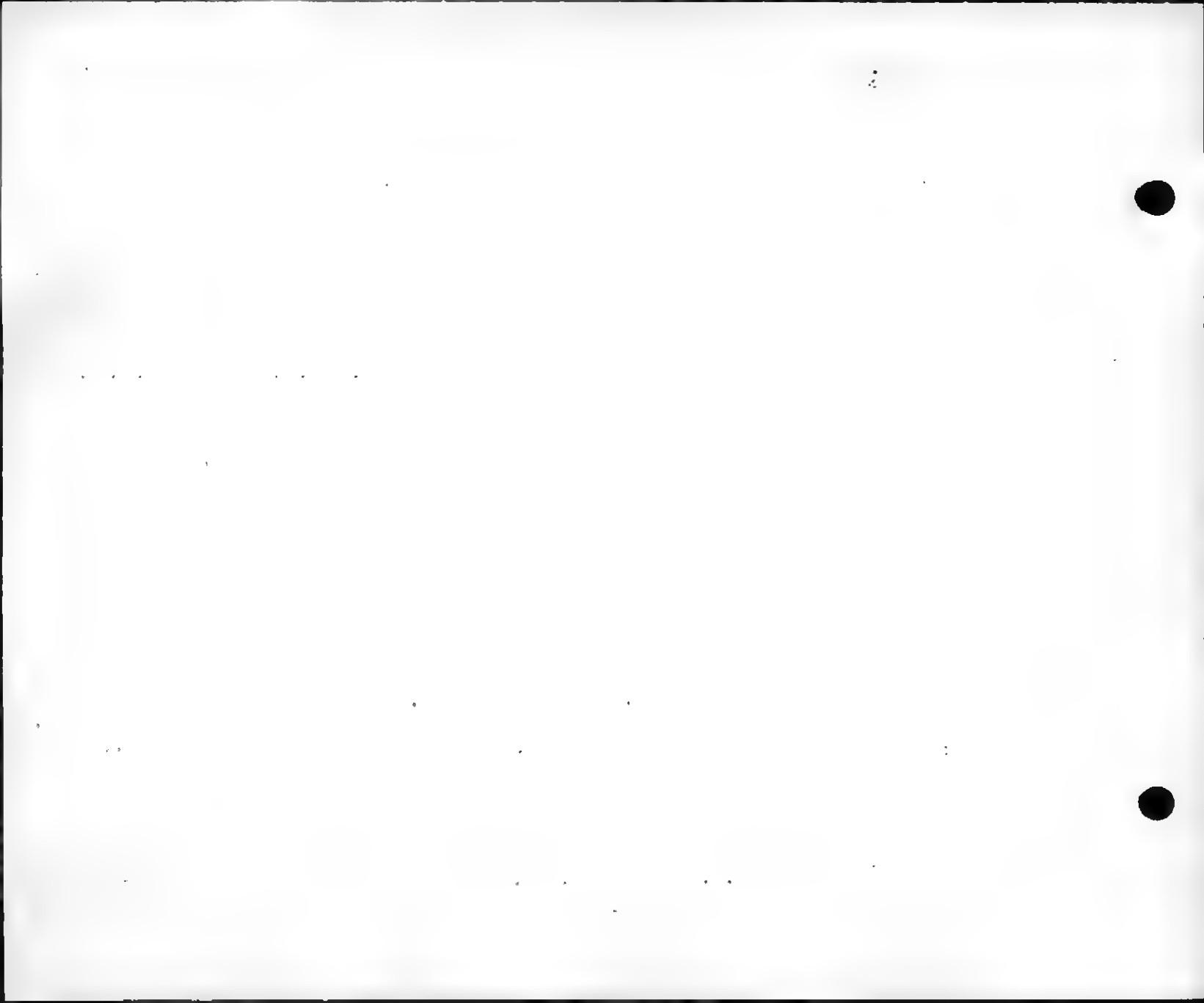
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04293

1 PLACE OF DEATH a COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b>	c LENGTH OF STAY IN b <b>DOA</b>	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Landover</b>	d STREET ADDRESS <b>6825 Standish Drive</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>FELIX</b>	First <b>JOHN</b>	Middle <b>TOS</b>	4 DATE OF DEATH Month <b>3</b> Day <b>3</b> Year <b>1966</b>
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED W DIVORCED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	8 DATE OF BIRTH <b>30 April 1952</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b KIND OF BUSINESS OR INDUSTRY <b>School</b>	9 AGE (in years last birthday) <b>13 yrs</b>
13 FATHER'S NAME <b>Edward</b> Tos		11 BIRTHPLACE (State or foreign country) <b>Passaic Co., N.J.</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>none</b>	17 INFORMANT Address <b>Edward Tos Same as #2 (father)</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral hemothorax</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>From multiple rib fractures</b> (c) DUE TO <b>Laceration of brain</b> (d) DUE TO <b>From fracture of skull</b>		INTERVAL BETWEEN ONSET AND DEATH min. <b> </b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b) <b>Pedestrian struck by car.</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>8:25 pm p.m. 3-3- 1966</b>		20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 202, in front of 6501 Landover Rd., Prince George County, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <b>John Kehoe, M.D. Riverdale, Md.</b>	
23a BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	23b DATE THEREOF <b>3/4/66</b>	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Santangelo Funeral Home</b>	23d LOCATION (City or Town) (County), (State) <b>West Paterson, Passaic, N.J.</b>
24 FUNERAL DIRECTOR <b>Francis Marchese Sons Hyattsville, Md.</b>	25a REC'D BY REGISTRAR DATE <b>MAR 7 1966</b>	25b REGISTRAR'S SIGNATURE <i>John Kehoe</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

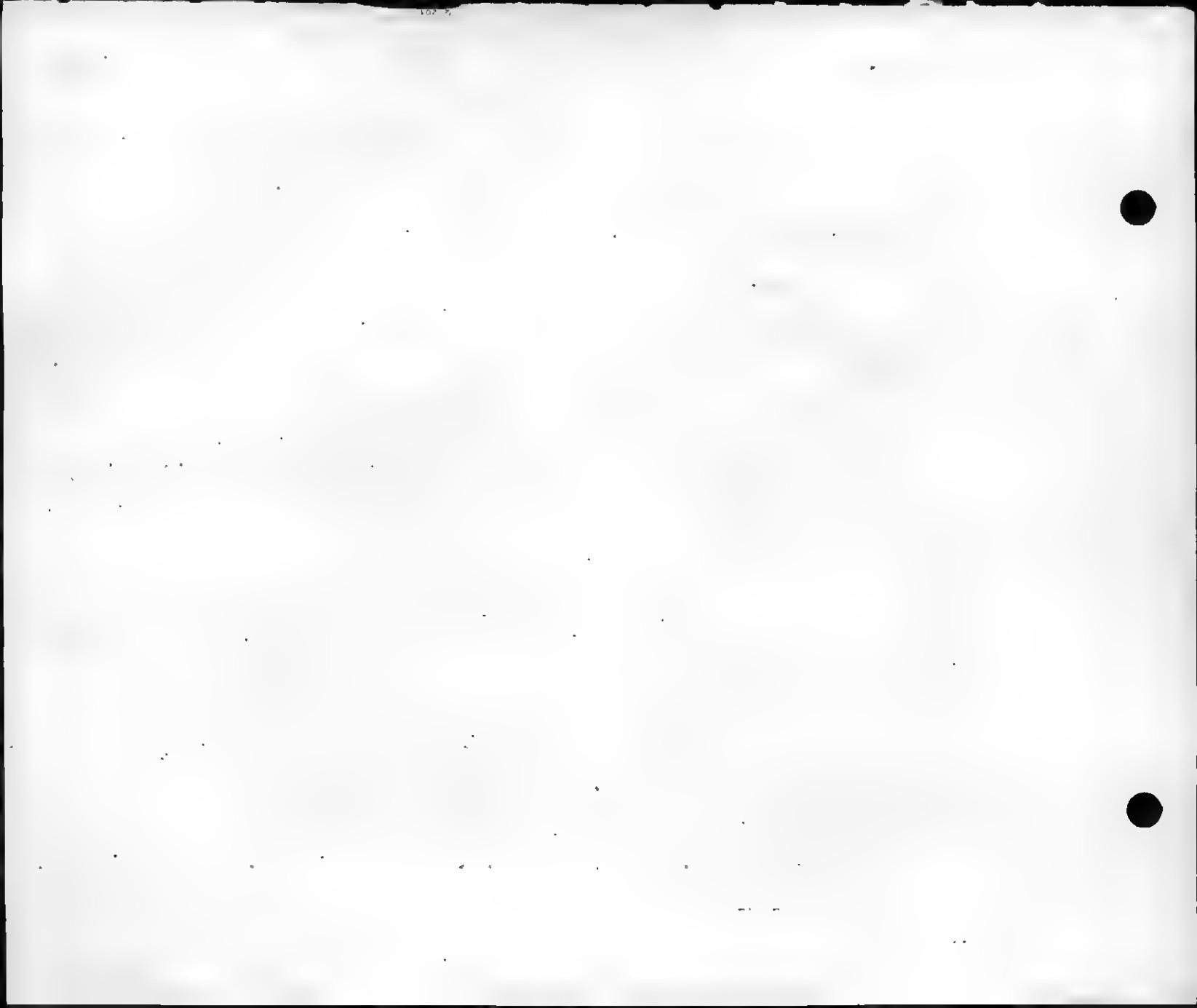
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04294

04300

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b <b>23 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suitland Nursing Home, Inc.</b>		e. STREET ADDRESS <b>327 Huron Drive</b>	
3. NAME OF DECEASED (Type or print)	First <b>Marie</b>	Middle <b>J.</b>	Last <b>Trester</b>
4. DATE OF DEATH <b>March 8, 1966</b>	Month <b>March</b>	Day <b>8</b>	Year <b>1966</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <b>12-28</b>
9. AGE (In years at last birthday) <b>88 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	13. FATHER'S NAME <b>James Plunkett</b>		
14. MOTHER'S MAIDEN NAME <b>Susan Nagle</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Doris Trester Forest Hts., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>+200</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cedar Hill Cemetery</b>
20f. (City or town) <b>Suitland</b>		(County) <b>Maryland</b>	
(State) <b>MD</b>			
21. I certify that (I) (We) attended the deceased from <b>1956</b> to <b>1966</b> , to <b>3/8/66</b> , that (I) (We) last saw the deceased alive on <b>3/3/66</b> , and that death occurred at <b>1:55 P.M.</b> from the causes and on the date stated above.		22d. ADDRESS <b>Timothy J. O'Donovan, M.D. 4400 Stamp Rd., Temple Hills, Md.</b>	
22a. SIGNATURE <b>John O'Donovan</b>		22b. DATE SIGNED <b>3/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Timothy J. O'Donovan, M.D.</b>		22d. ADDRESS <b>4400 Stamp Rd., Temple Hills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-10-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>
23d. LOCATION (City, town or county) <b>Suitland</b>		(State) <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		ADDRESS <b>4308 Suitland Rd Suitland Maryland</b>	
25a. REC'D BY REGISTRAR <b>MAR 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

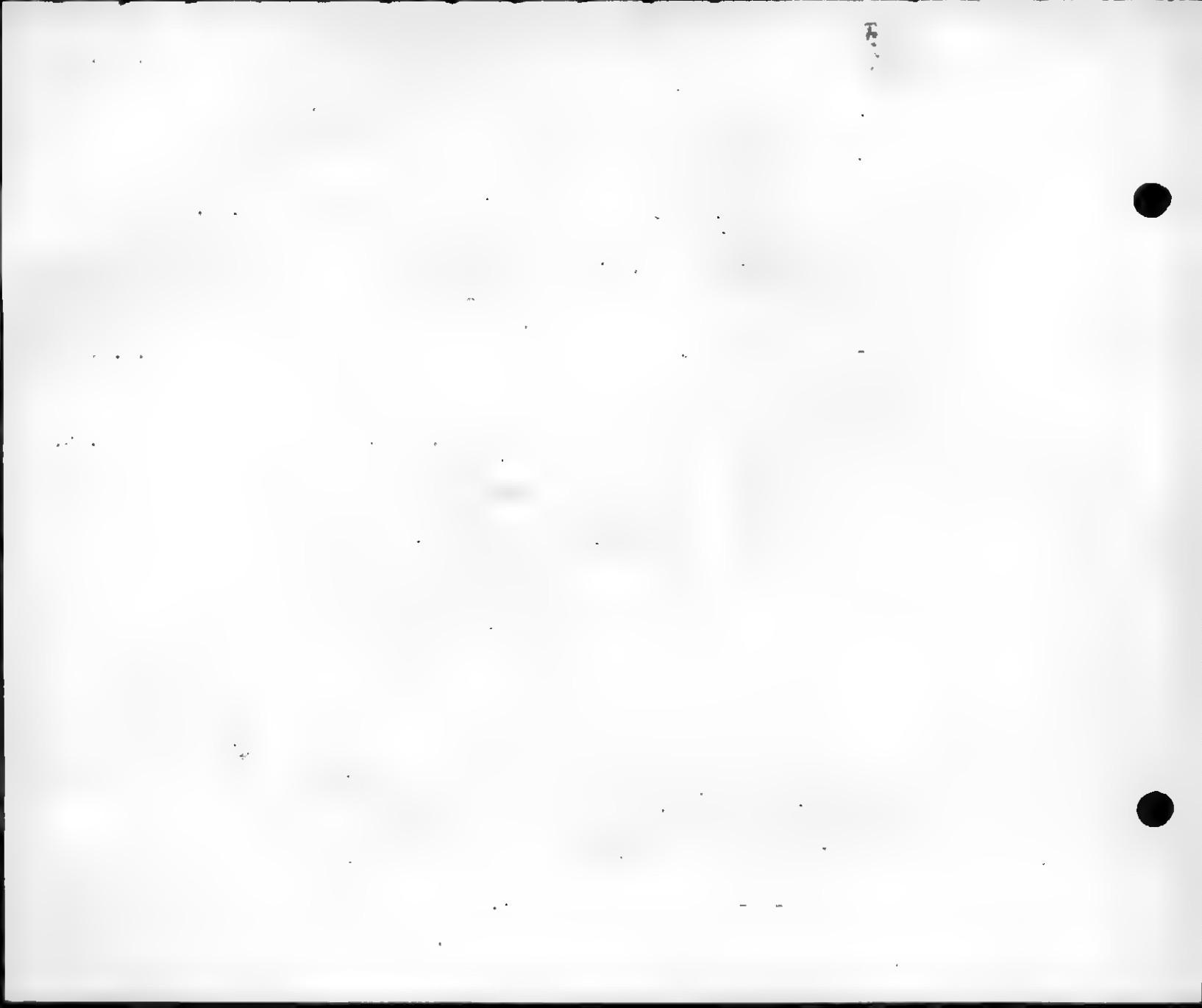
**CERTIFICATE OF DEATH**

04295

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brandywine-Waldorf Clinic		e. STREET ADDRESS 918 14th Street, S. E.		
3. NAME OF DECEASED (Type or print) <i>Roger Dixon Trueman</i>		4. DATE OF DEATH March 26 1966	b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male White 6. COLOR OR RACE WIDOWED DIVORCED 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-3-1899	9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Salesman		10b. KIND OF BUSINESS OR INDUSTRY Baking Company	11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Joshua Trueman		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Adelia L. Trueman	17. INFIRMANT Address 918 14th Street, S. E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN DNSET AND DEATH <i>3 days</i>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocard infarction</i>				
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>Senile cardiovascular disease</i>				
DUE TO (b) <i>Senile cardiovascular disease</i>				
DUE TO (c) <i>Senile cardiovascular disease</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-11 1963, to 5-26 1966, that (we) last saw the deceased alive on 3-26 1966, and that death occurred at 1:28 PM, from the causes and on the date stated above.				
22a. SIGNATURE <i>S. Richard Hobson</i>		22b. DATE SIGNED <i>2-11-63</i>		
22c. PHYSICIAN'S NAME (Type) Richard Hobson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Brandywine Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-66	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Rd Suitland Maryland	25a. REC'D BY REGISTRAR MAR 31 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

HOSPITAL OR ATTENDING PHYSICIAN  
Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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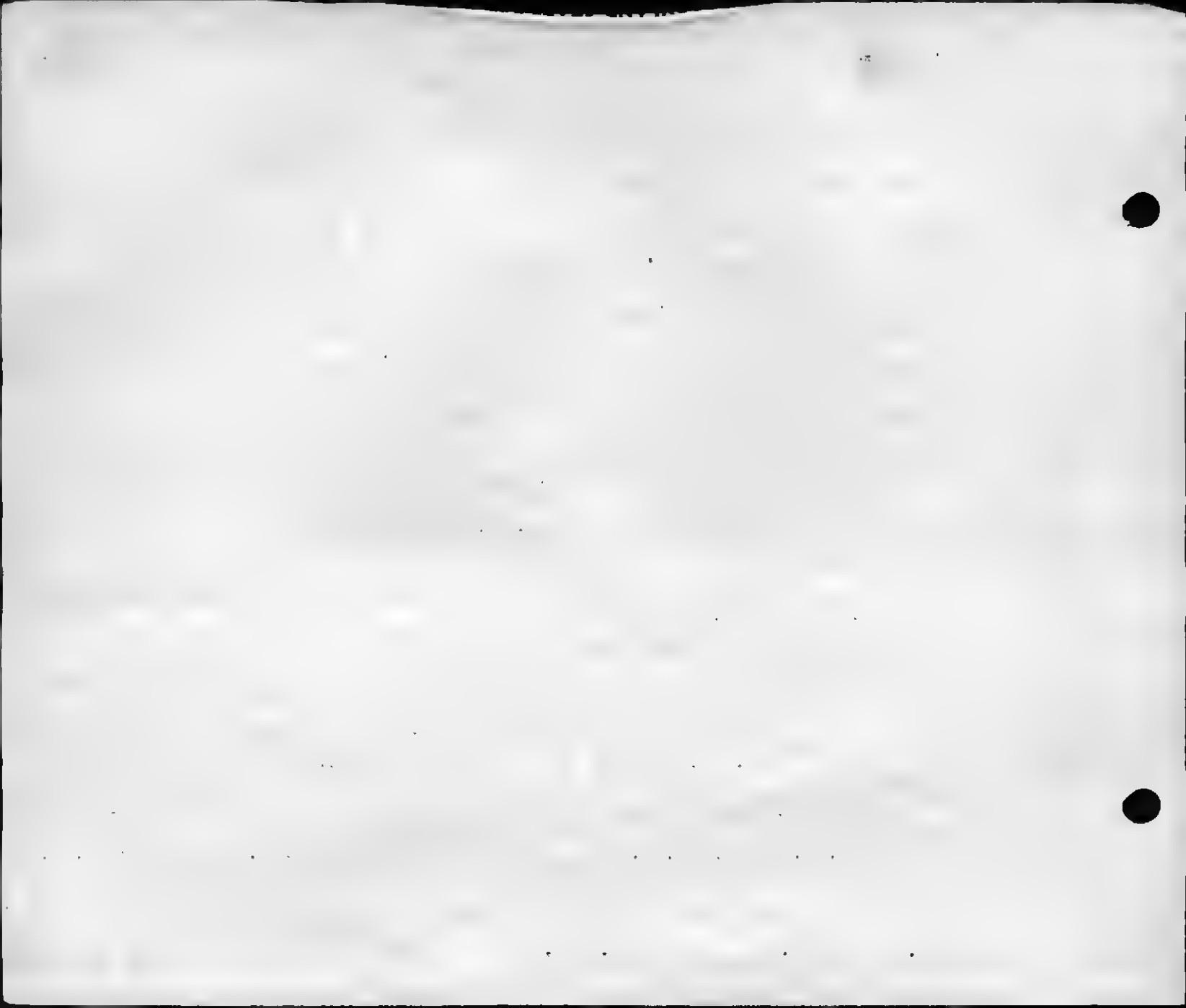
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04296

04302

1. PLACE OF DEATH a. COUNTY <u>Prince George</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>		b. COUNTY <u>Prince George</u>	
c. LENGTH OF STAY IN lb <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5102 23rd. Parkway</u>		d. STREET ADDRESS <u>5102 23rd. Parkway</u>	
3. NAME OF DECEASED (Type or print) <u>Anna May Van Triggle</u>		4. DATE OF DEATH Year <u>1965</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1900</u>	
9. AGED (In years last birthday) <u>70 yrs.</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kentucky</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Hostetter</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give rank or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>70-771-314</u>	
17. INFORMANT <u>Dr. M. Stolar</u>		Address <u>1801 Eye St., N. W. Washington, D. C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of the pancreas</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>OCTOBER 12, 1965</u> <u>MARCH 21, 1966</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15, 1966</u> , to <u>March 21, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 15, 1966</u> , and that death occurred at <u>6:00 p.m.</u> M. from the causes and on the date stated above		22b. DATE SIGNED <u>March 22, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. H. Stolar, M. D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1801 Eye St., N. W. Washington, D. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. Ryan, Inc.</u>		ADDRESS <u>317 E. Av., 31203</u>	
		25a. REC'D. BY REGISTRAR <u>J. Charles Judge</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04303

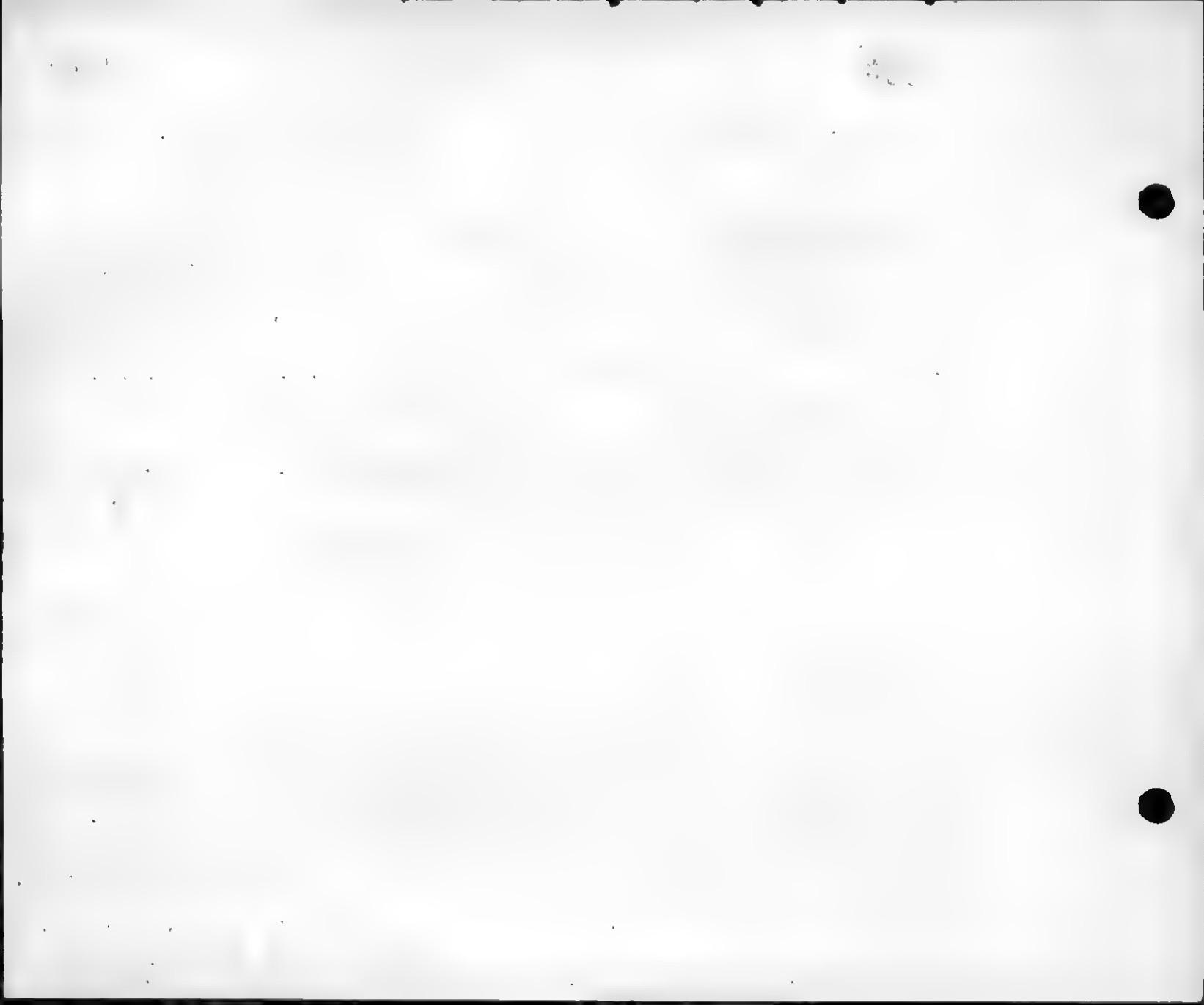
## CERTIFICATE OF DEATH

04297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Magnolia Rest Home</b>		d. STREET ADDRESS <b>6319 51st Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>BERTHA</b>	Middle	Last <b>WALKER</b>	4. DATE OF DEATH Month <b>March</b>	Day <b>15,</b>	Year <b>1966</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1885</b>	9. AGE (In years last birthday) <b>80 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Goverment</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>August Beckmann</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Schneider</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>217 52 9077</b>		17. INFORMANT <b>Doris White Same as #2 (daughter)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a) } stating the underlying cause } last. (b) } DUE TO (c) }				INTERVAL BETWEEN ONSET AND DEATH <b>6 hr.</b> From			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>3118</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19, to <b>3/15</b> , 1966, that (I) (we) last saw the deceased alive on <b>3/11/66</b> and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Leon Levitsky</b>		M.D. ATTENDING PHYS. <b>4 MED. DIRECTOR</b>		STAFF PHYS. <b>22b. DATE SIGNED Mar 15, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leon Levitsky</b>		22d. ADDRESS <b>3408 Rhode Island ave Mt Rainier, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/17/66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**PAGE 4** may be retained by the hospital or attending physician.

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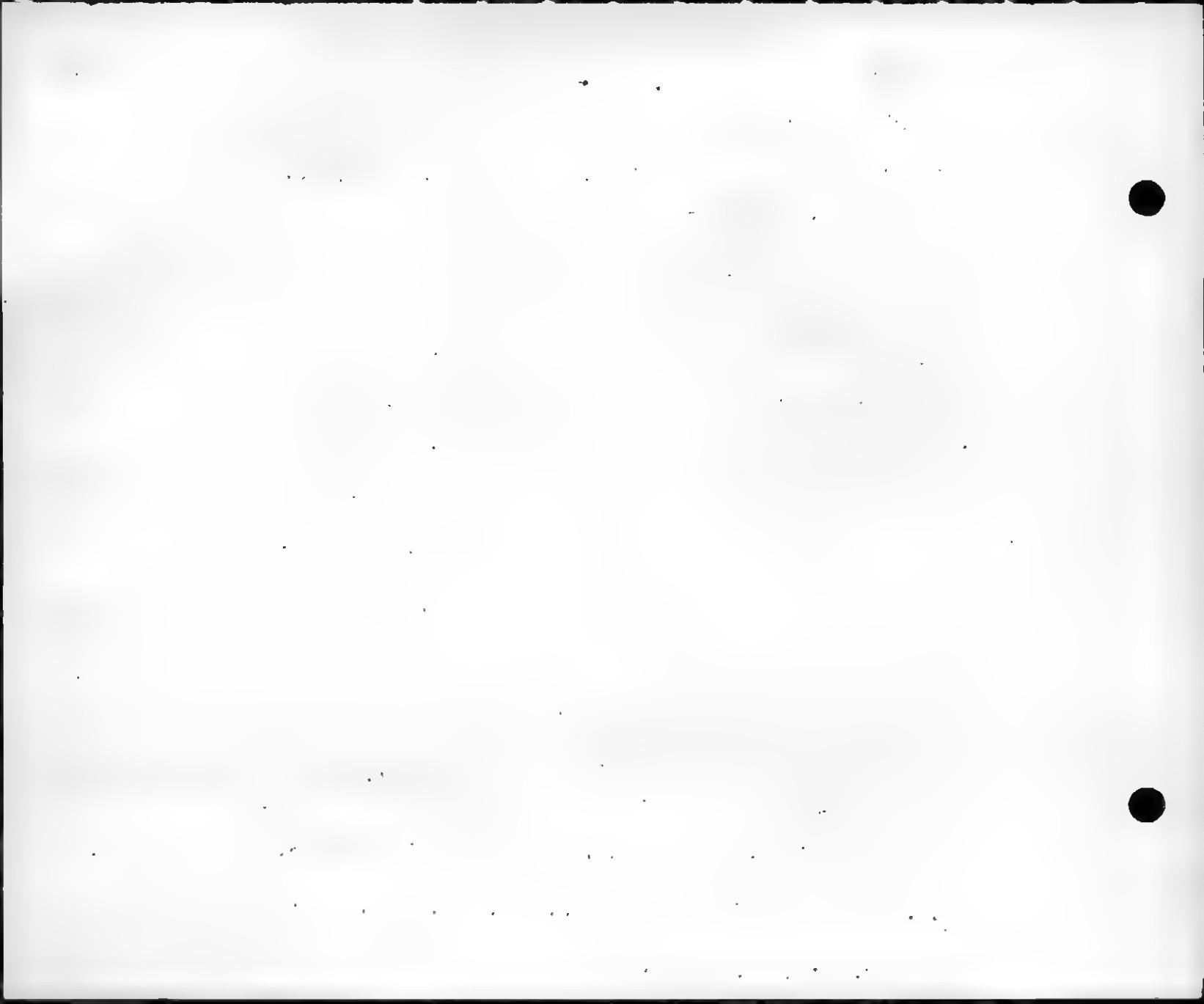
**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**04306**

**CERTIFICATE OF DEATH**

**04299**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>PG</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>4 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chillum Hghts.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General</b>		d. STREET ADDRESS <b>5728 Chillum Hghts</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <b>Baby Girl</b>	Middle <b>Watts</b>	Last 4. DATE OF DEATH DF DEATH <b>3 20 1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/20/66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Michael Francis Watts</b>		14. MOTHER'S MAIDEN NAME <b>Linda Lee Keller</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>				
17. INFORMANT <b>Mother</b>		Address <b>above</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3/20/66</b>	20f. (City or town) <b>Riverdale</b>	(County) <b>Riverdale</b>	(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>3/20/66</b> to <b>3/20/66</b> , that (I) (we) last saw the deceased alive on <b>3/20/66</b> , and that death occurred at <b>7:30 PM</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>3/21/66</b>				
22a. SIGNATURE <i>John W. Perkins</i>		22b. ADDRESS <b>6201 Riverdale Rd., Riverdale, Md.</b>				
22c. PHYSICIAN'S NAME (Type) <b>John W. Perkins, M.D.</b>		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>4/2/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Prince Geo. Gen. Hosp.</b>	23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>		
24. FUNERAL DIRECTOR <i>Henry W. Penn, Jr.</i>		25a. REC'D BY REGISTRAR <b>APR 7 1966</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
20M 1/65 <i>Henry W. Penn, Jr., Administrator</i>						



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04300

M  
6305

## CERTIFICATE OF DEATH

Items 3, 14 film 657 4/1/66 m-

1. PLACE OF DEATH  
a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN 16

3½ months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Sacred Heart Home

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Nellie

McLendon  
McLendor

Last

4. DATE  
OF  
DEATH

337 Maryland Avenue, N.E.

Month

Day

Year

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED  

NEVER MARRIED

 DIVORCED

## 8. DATE OF BIRTH

April 11, 1900

9. AGE (In years  
last birthday)

65 yr.

10. IF UNDER 1 YEAR  
Months Days11. IF UNDER 24 HRS.  
Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County &amp; State, or foreign country)

Clerical Work

Texas

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

John A. Weaver

## 14. MOTHER'S MAIDEN NAME

McLendon  
McLendor

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war record and service)

None

16. SOCIAL SECURITY NO. | 17. INFORMANT

Nellie

INTERVAL BETWEEN  
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

170X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

578-32-8174 Sacred Heart Home, Hyattsville, Md.

Toxemic

Generalized Cerebral

Cerebral Bleeding

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year  
Hour e.m. 20d. INJURY OCCURRED  
While Not While  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Feb 25, 1966 to Dec 14, 1966, that (I) (we) last  
saw the deceased alive on Dec 11, 1966, and that death occurred at 3 AM from the causes and/or the date stated above.

## 22a. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.  22b. DATE  
SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 3/17/66

23c. NAME OF CEMETERY OR CREMATORIAL

Cerar Hill Cemetery

23d. LOCATION (City, town or county)

Fredericksburg, Pa.

## 24. FUNERAL DIRECTOR'S SIGNATURE

Raskin &amp; Wolfson

## ADDRESS

4th, St. N.E. D.C.

25e. REC'D BY REGISTRAR

MAR 18 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

012

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12  
FOR STATE M  
HEALTH DEPT.

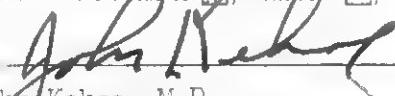
04306

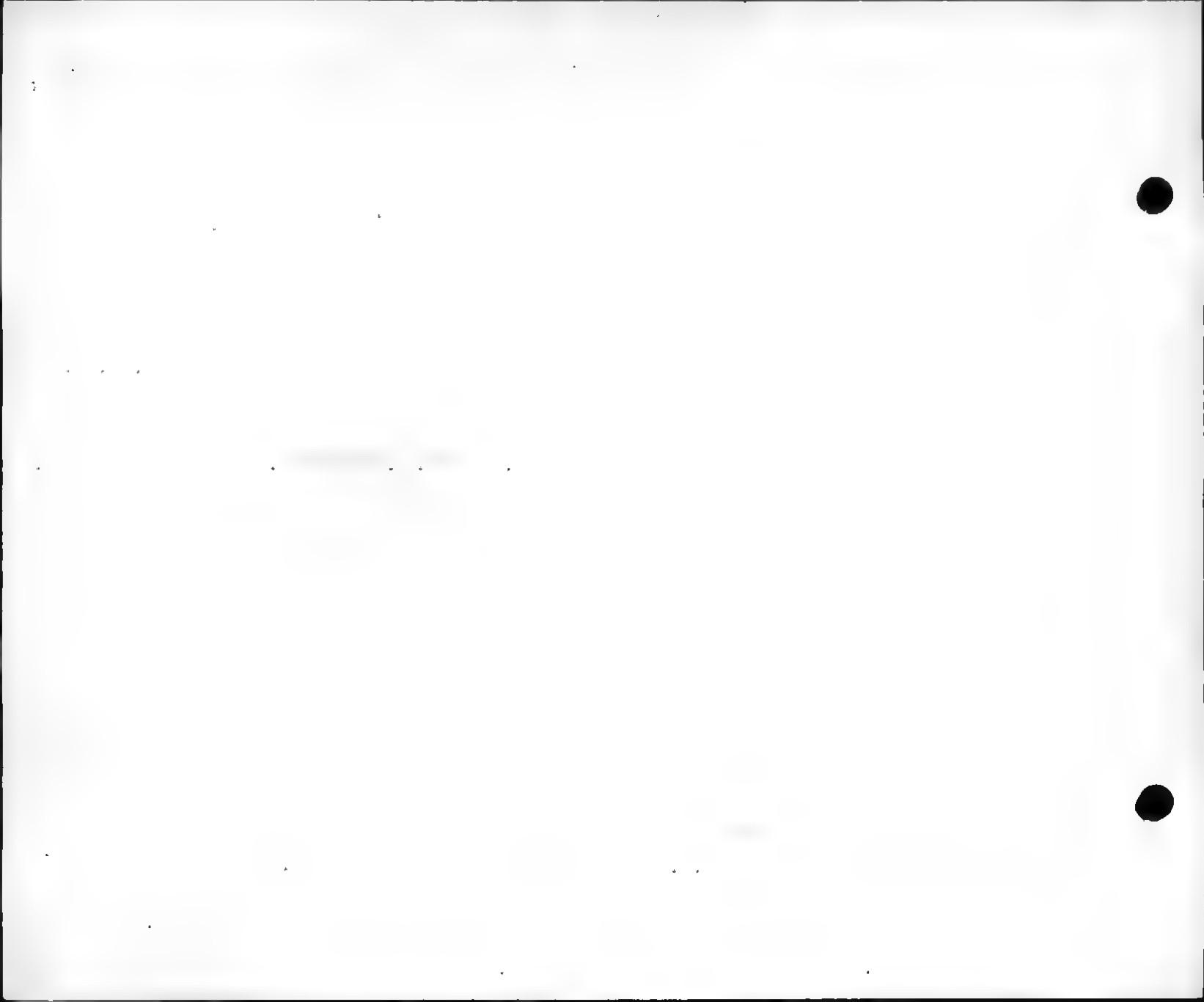
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04301

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit! File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Prince George's</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's Hospital</b>		e STREET ADDRESS <b>Route 4 Oldtown Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>Violet Alice Weber</b>		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4 SEX <b>female</b>	5 COLOR OR RACE <b>white</b>	6 MARRIED MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7 NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <b>Nov. 5, 1908</b>
9 AGE (in years less birthday) <b>77 5/12</b>		10 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11 BIRTHPLACE (State or foreign country) <b>Bedford County, Penna.</b>		12 ADDRESS <b>111 N. Main Street, Cumberland, Md.</b>	
13 FATHER'S NAME <b>James Bagley</b>		14 MOTHER'S MAIDEN NAME <b>Etta Drenning</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>215-12-2171</b>	
17. INFORMANT <b>Mr. Virgil O. Weber Rt. # 4 Cumberland, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO (c) DUE TO (d)	
		Heart failure	
		Rupture of aneurysm of aortic valve	
		Arteriosclerotic heart disease	
		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Reticulum cell sarcoma of stomach - over two months</b>		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or Town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>3-9-66</b>	
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <b>Riverside Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/12/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>DAMAR 14 1966</b>	
		25b. REGISTRAR'S SIGNATURE 	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

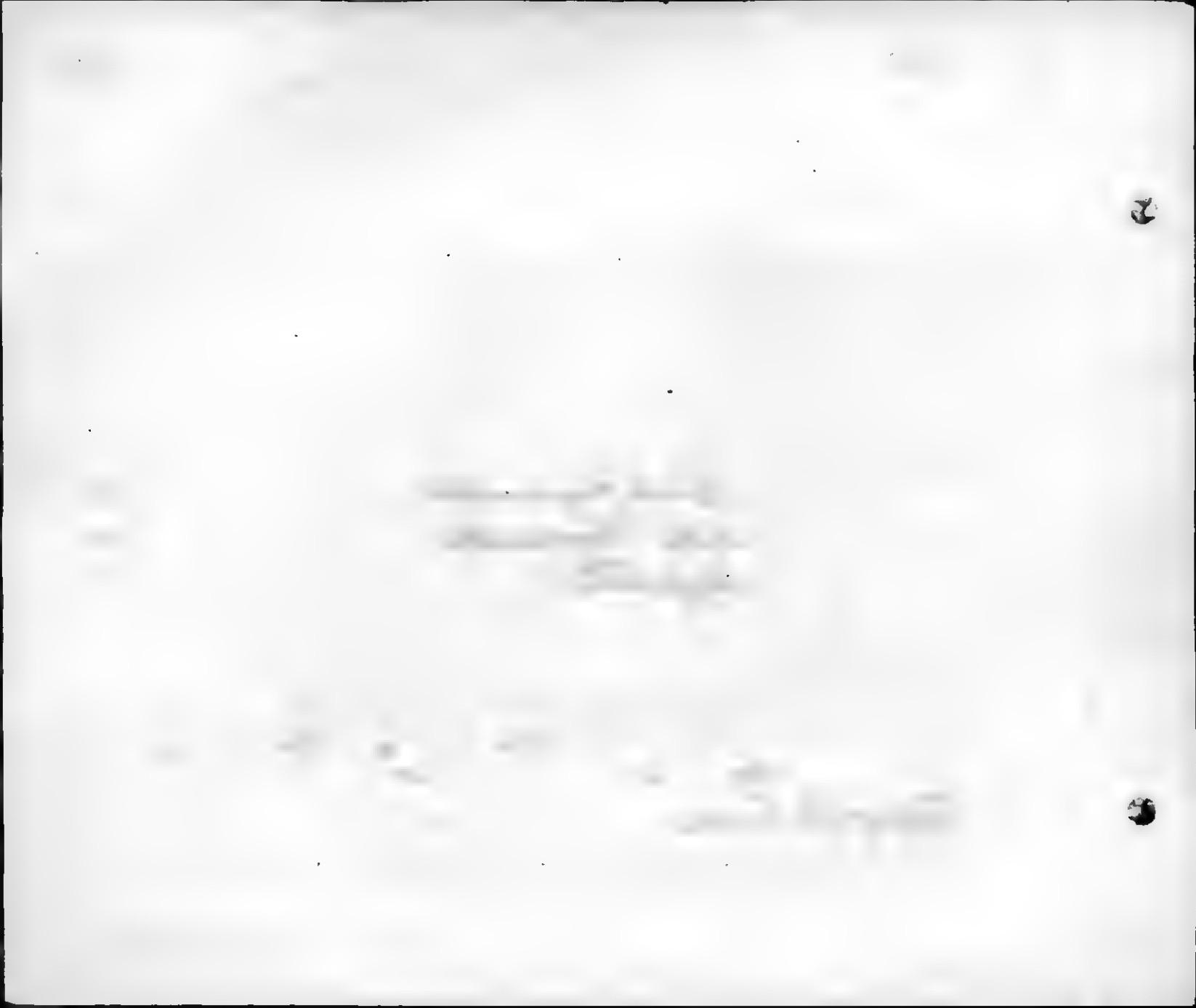
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

04302

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Rural 2 mos		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md		b. COUNTY Howard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1100 Montgomery Street</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Scrogginsville</i>			
3. NAME OF DECEASED (Type or print) <i>ANNA MARTHA WEHLAND</i>		First	Middle	Last	4. DATE OF DEATH <i>March 16 1966</i>	Month	Day	Year	
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 27 1883</i>	9. AGE (in years lost birthday) <i>83 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>C.S.A.</i>			
13. FATHER'S NAME <i>Hermon Damm</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Jaeger</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Vernon Weiland, Laurel, Md</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>43 X</i> DUE TO <i>Anute Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Lahr Myocarditis</i> (c) DUE TO <i>Hypertension</i>		3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>5/15 1966</i>		(County) <i>Laurel</i>	(State) <i>Md</i>
21. I certify that (I) (this hospital) attended the deceased from <i>5/15 1966</i> to <i>5/16 1966</i> , that (I) (we) last saw the deceased alive on <i>5/16 1966</i> . and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Robert S. McCeney</i>		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>5/16 1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>Robert S. McCeney, M.D.</i>		22d. ADDRESS <i>402 Main St., Laurel, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-19-66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St Paul Cemetery</i>		23d. LOCATION (City, town, or county) <i>Fultons Md</i>		(State) <i>Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Scott Donaldson, Laurel Md</i>		ADDRESS <i>—</i>		25a. REC'D BY REGISTRAR <i>MAR 22 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

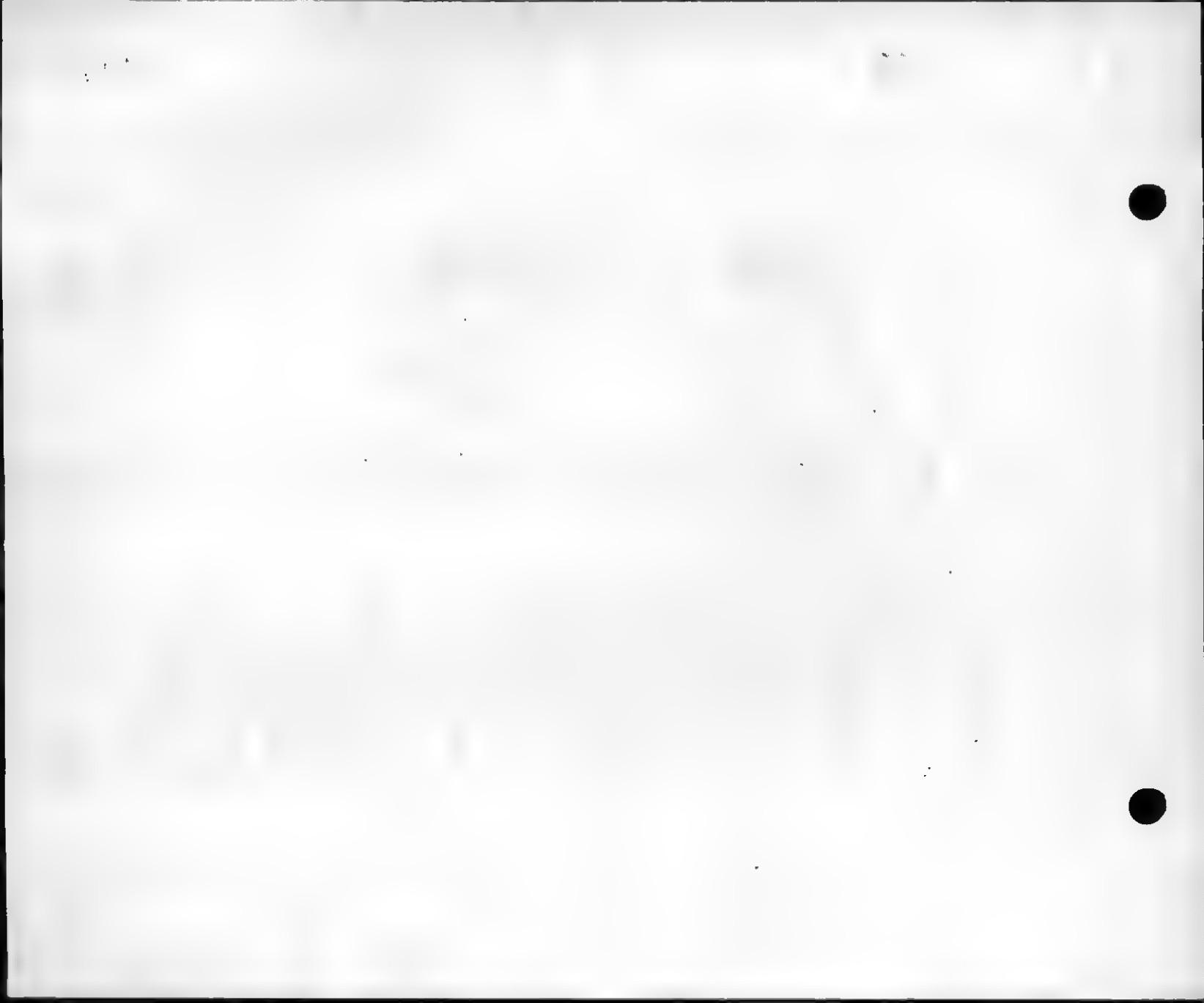
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

24308

CERTIFICATE OF DEATH

114303

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>500 Swann Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>L.</b>	Last <b>Weisbacker sr</b>			
4. DATE OF DEATH Month <b>March</b>	Day <b>7</b>	Year <b>1966</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8/1923</b>			
9. AGE (In years last birthday) <b>43 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired policeman</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME <b>Frank L. Weisbacker</b>	14. MOTHER'S MAIDEN NAME <b>Mabel M. Linkins</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	16. SOCIAL SECURITY NO. <b>519-16-5370</b>			
17. INFORMANT <b>Mrs Helen A. Weisbacker</b>	Address <b>500 Swann Rd Suitland, Md</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkin's Sarcoma</b>	INTERVAL BETWEEN ONSET AND DEATH <b>13 mo</b>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>x01X</b>	DUE TO (b) <b></b>	DUE TO (c) <b></b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>
21. I certify that (I) (this hospital) attended the deceased from <b>2-10</b> , 19 <b>65</b> , to <b>3-7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-4</b> 19 <b>66</b> , and that death occurred at <b>150</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>John P. D'Angelo MD</b>		22b. DATE SIGNED <b>2-10-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>John P. D'Angelo</b>		ATTENDING PHYS. <b>M.D.</b>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/10/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (city, town or county) <b>Ft. Myer</b>	(State) <b>Va</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		ADDRESS <b>Washington, D. C.</b>	25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



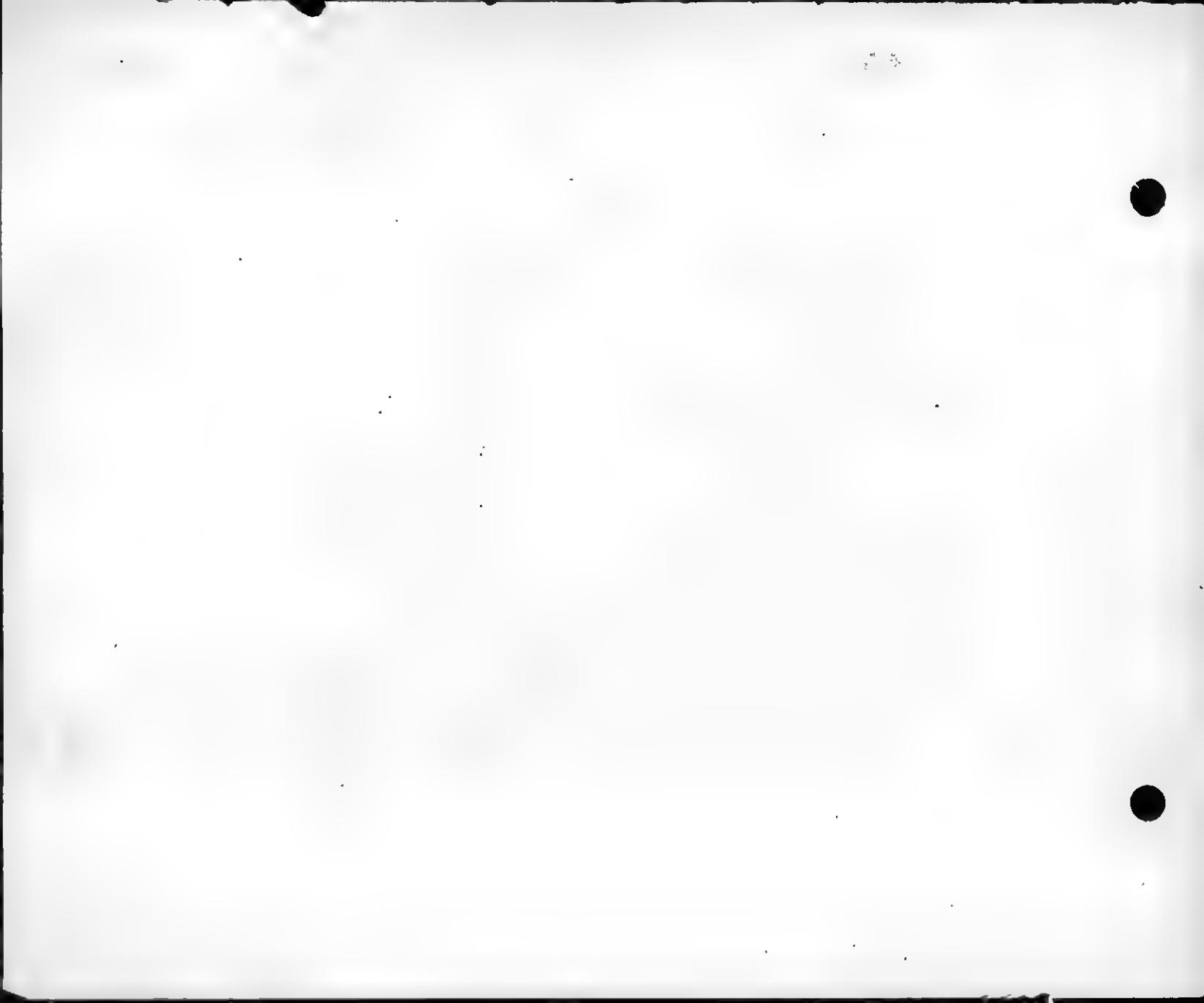
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14309 143114

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>St. Marys</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Charlotte Hall</i>		c. LENGTH OF STAY IN 1b <i>16 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Southern Maryland General</i>		d. STREET ADDRESS <i>Charlotte Hall</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Edward</i>	Middle <i>William</i>	Last <i>Whalen</i>	4. DATE OF DEATH <i>Mar. 12 1966</i>	Month <i>Mar.</i>	Day <i>12</i>	Year <i>1966</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-10-93</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	Months <i>72</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Duobor Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Edward George Whalen</i>		14. MOTHER'S MAIDEN NAME <i>Holiday</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Lewis Whalen</i>		17. INFORMANT <i>charlotte Hall</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Ca of stomach. myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Charlotte Hall</i>		20f. (City or town) <i>Charlotte Hall</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-24</i> , 19 <i>66</i> , to <i>3-12</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3-12</i> , 19 <i>66</i> , and that death occurred at <i>9:30</i> P.M. from the causes and on the date stated above.		22b. DATE SIGNED <i>3-24-66</i>							
22a. SIGNATURE <i>B. Maldonado Jr.</i>		22c. PHYSICIAN'S NAME (Type) <i>Benjamin Maldonado Jr.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-16-66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Calvary Ch. Cemetery</i>		23d. LOCATION (City, town or county) <i>Charlotte Hall, Md.</i>		(State)	
24. FUNERAL DIRECTOR <i>Martell Adams Aquinas, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 (4) 20M 1/65		DATE <i>MAR 21 1966</i>							



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

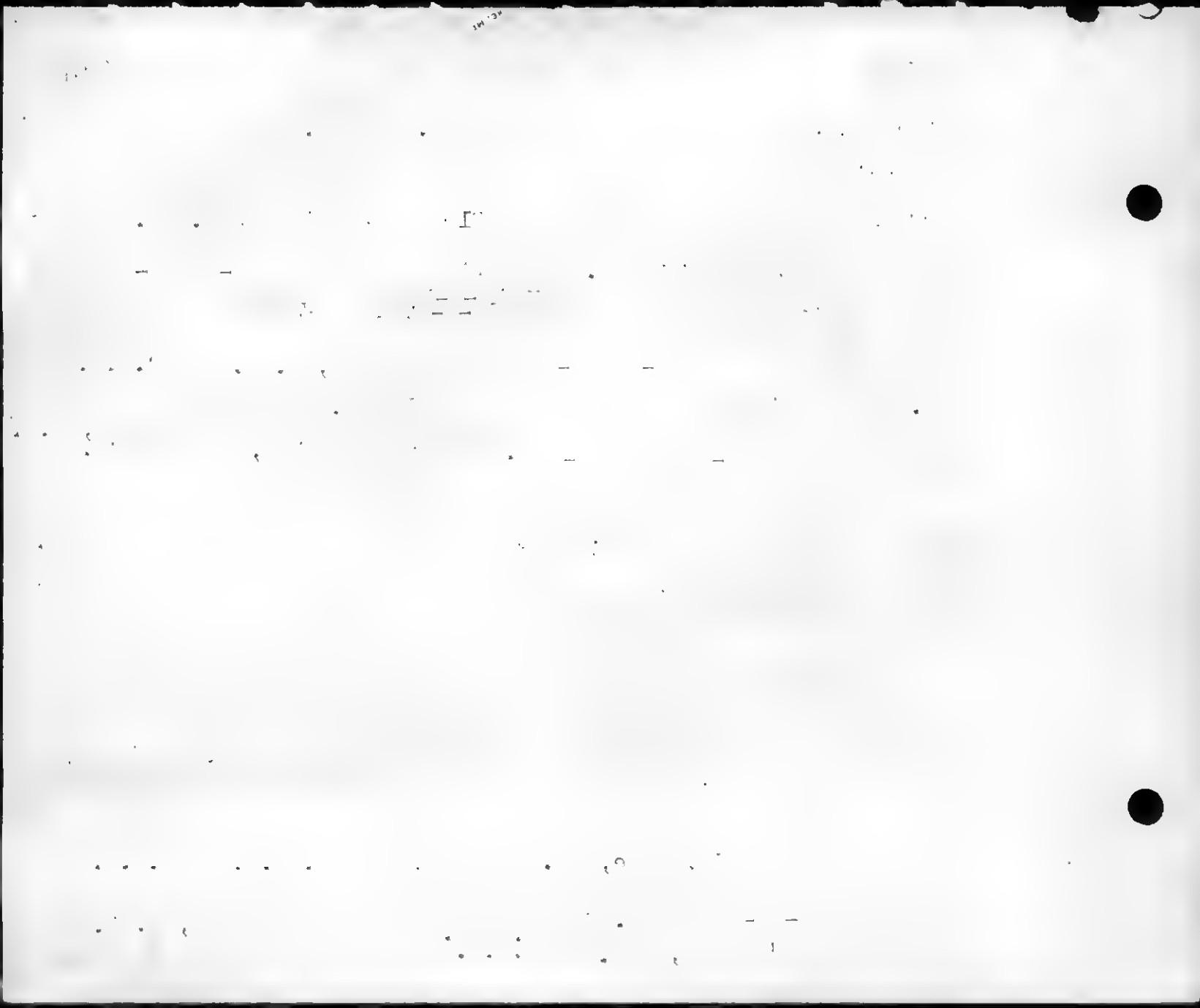
## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M		04310		1143105	
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Dist. of Col.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Manor Nursing Home</b>		d. STREET ADDRESS <b>2100 Connecticut Ave. N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Margaret</b>	Middle <b>A.</b>	Last <b>White</b>	4. DATE OF DEATH Month <b>3</b>	Day Year <b>12 1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-6-1898</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>J. Frank White</b>		14. MOTHER'S MADDEN NAME <b>Ellen L. Spottswood</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. —		17. INFORMANT Address <b>H. Spottswood White, 40 Wall St., New York, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b>					
733X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypercalcemia</b> (c) <b>Osteoporosis</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b>					
3 Mos.					
5 Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) factory, street, office/bldg., etc.	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> , 19 <b>66</b> , to <b>3/12</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/12</b> , 19 <b>66</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <i>Louis Gillespie, Jr.</i>		22b. DATE SIGNED <b>3/17/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Louis Gillespie, Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>1714 N St. N.W. Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-15-1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>	
23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc. Wash.D.C.</b>		23e. ADDRESS <b>5100 Wisconsin Ave.</b>		23f. REC'D BY REGISTRAR <b>Washington, D.C.</b>	
23g. REGISTRATION SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 17 1966</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04311

## CERTIFICATE OF DEATH

04306

Item 620, Form 1562, 1960, rev.

## 1. PLACE OF DEATH

## e. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Oxon Hill

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6310 Dominion Dr.

## c. LENGTH OF STAY IN 1b

3. NAME OF  
DECEASED  
(Type or print)

First William

Middle A.

Last White, Jr.

4 DATE  
OF  
DEATH March 20,

Month Year 1966

## 5. SEX

## 6. COLOR OR RACE

Male

White

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## b. DATE OF BIRTH

Nov. 26, 1893

9. AGE (in years  
last birthday)

72 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Principal

10b. KIND OF BUSINESS OR INDUSTRY

Public School

11. BIRTHPLACE (County &amp; State, or foreign country)

Randolph Co., N. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

William A. White

## 14. MOTHER'S MAIDEN NAME

Roxie Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown)  If yes give rank or date of service

16. SOCIAL SECURITY NO.

17. INFORMANT

## Address

Mrs. Waldeen H. White 6310 Dominion Dr., Oxon Hill, Md.

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

## DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last. } (b)

## DUE TO

## (c)

INTERVAL BETWEEN  
ONSET AND DEATH

2 wks

Cerebral vascular accident

Cerebral Arteriosclerosis

6 yrs

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY  
Hour a.m.  
p.m. 1920d. INJURY OCCURRED  
While at work  Not While at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on 9 March 20, 1966, and that death occurred at 11:15 P.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)23e. BURIAL, CREMATION, REMOVAL (Specify)  
Burial 3/24/66

24 FUNERAL DIRECTOR'S SIGNATURE

Everly-Wheatley Funeral Home Alexandria, Virginia

ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS. 

22d. ADDRESS

3407 N. 61st Ave S.E.

22b. DATE  
SIGNED 3-26-66

23c. NAME OF CEMETERY OR CREMATORIAL

New Garden

23d. LOCATION (City, town or county) (State)

Guilford College, N. C.

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAR 24 1966

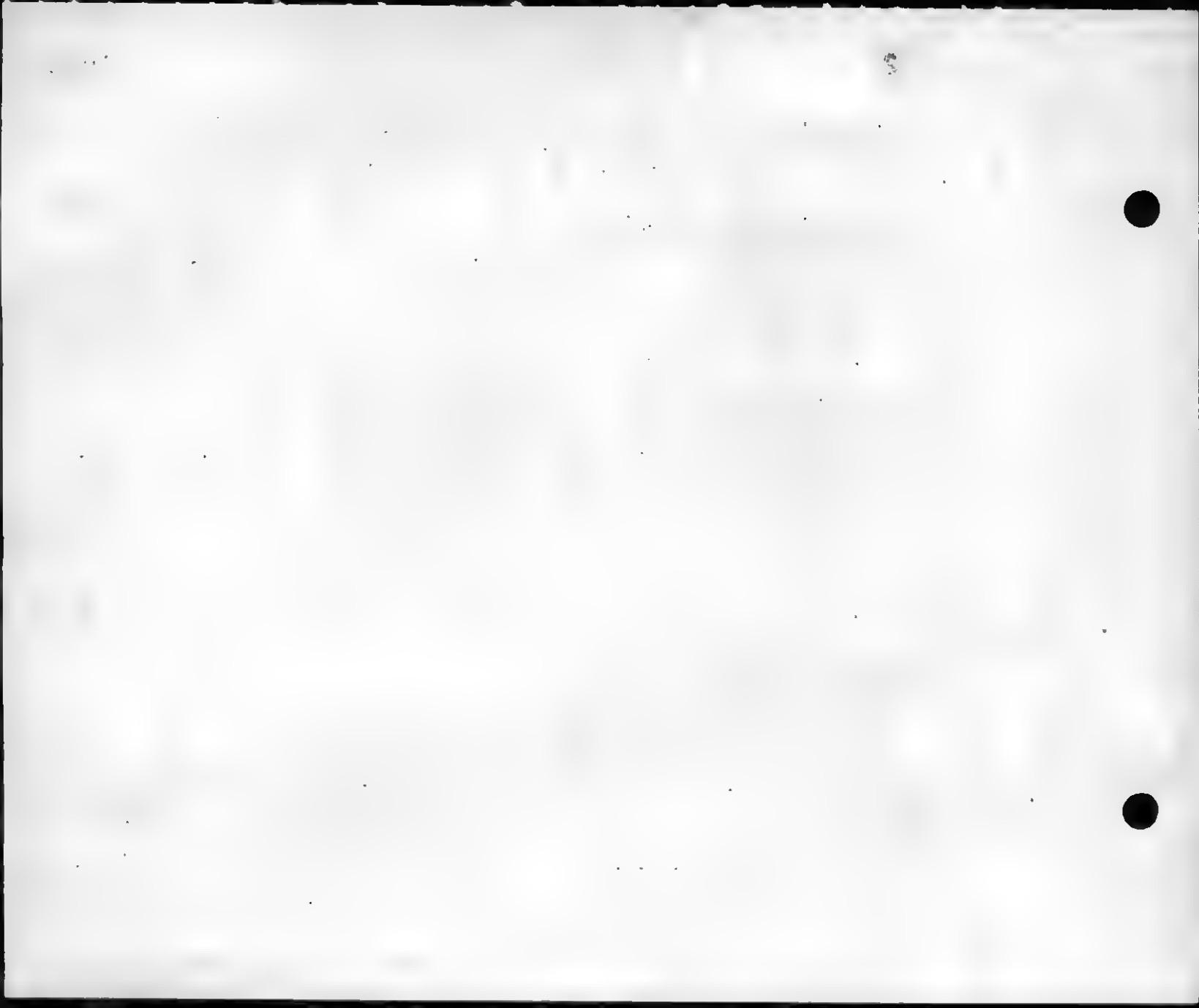
Charles Judge



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY <b>Prince George's</b> MARYLAND				a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN LB <b>1 day</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>3308 Rosemary Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>Baby</b>	Middle <b>Boy</b>	Last <b>Wilberger</b>	4. DATE OF DEATH	Month <b>March</b>	Day <b>15</b>	Year <b>1966</b>								
5. SEX	6. COLOR OR RACE <b>Male White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>WIDDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 14, 1966</b>	9. AGE (in years last birthday) <b> yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	IF UNDER 1 YEAR Months <b>1</b>				IF UNDER 24 HRS Days <b>1</b> Hours <b>0</b> Min. <b>0</b>			
13. FATHER'S NAME <b>Robert Wilberger</b>	14. MOTHER'S MAIDEN NAME <b>Christine Hansen</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>	16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Robert Wilberger</b>	Address <b>Hyattsville, Md.</b>												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b>															
776X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____															
DUE TO															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Colmar Manor, Md.</b>		(County) <b>Colmar Manor, Md.</b>		(State) <b>Colmar Manor, Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3-14</b> , 19 <b>66</b> , to <b>3-15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-14</b> , 19 <b>66</b> , and that death occurred at <b>1.45 M</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Aaron Deitz, M.D.</b>															
22b. DATE SIGNED <b>3/16/66</b>															
22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M.D.</b>				22d. ADDRESS <b>Prince George's Plaza, Hyattsville, Md.</b>											
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>March 18, 1966</b>				23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Lincoln</b>				23d. LOCATION (City, town or county) <b>Colmar Manor, Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's sons</b>				ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 21 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~retain~~ a carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

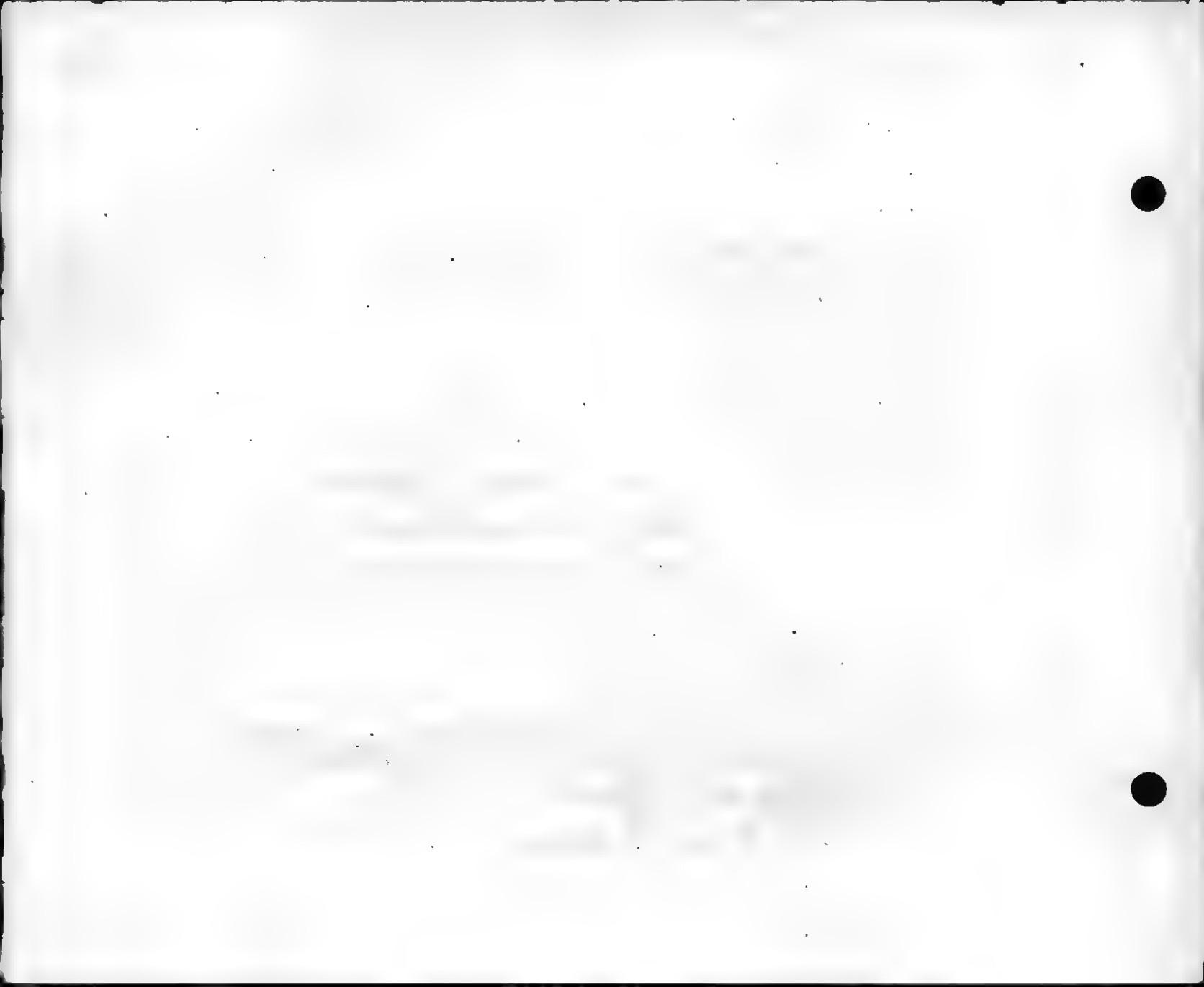
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04313

CERTIFICATE OF DEATH

04308

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON DOA</b>	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.R. Box 293</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>S.C. MD. Hosp. CENTER</b>	d. STREET ADDRESS <b>BRANDYWINE, MD.</b>				
3. NAME OF DECEASED (Type or print) <b>FRANCIS</b>	First <b>W.</b>	Middle <b>WILKINSON</b>	Last <b>FRANCIS</b>	4. DATE OF DEATH <b>MARCH 30 1966</b>	Month Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/13/88</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>TOBACCO</b>	11. BIRTHPLACE (County & State, or foreign country) <b>P.G. MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>RICHARD W. WILKINSON</b>	14. MOTHER'S MAIDEN NAME <b>SUSAN A. GARNER</b>	Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>214-36-2849</b>	17. INFORMANT <b>FRANCIS WILKINSON, BRANDYWINE, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1992</b>				<b>CARDIOVASCULAR COLLAPSE</b> <b>1/2 HR.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMATOSIS</b> (c) <b>CARCINOMA PROSTATIC &amp; RENAL</b>				<b>5 mos</b> <b>2 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>CLINTON, MD.</b>	(County) <b>BADEN, MD.</b>	(State) <b>MD.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>August 1966</b> to <b>March 30, 1966</b> , that (I) (we) last saw the deceased alive on <b>3/29/66</b> , and that death occurred at <b>9:45 AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Alfred R. Lafferty, M.D.</b>	22b. DATE SIGNED <b>3/30/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAFFERTY</b>	22d. ADDRESS <b>CLINTON, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-1-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>IMMANUEL Cem.</b>	23d. LOCATION (City, town or county) <b>BADEN, MD.</b>	(State) <b>MD.</b>	
24. FUNERAL DIRECTOR <b>Health Funeral Home Waldorf, Md.</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>APR 4 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	DATE	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

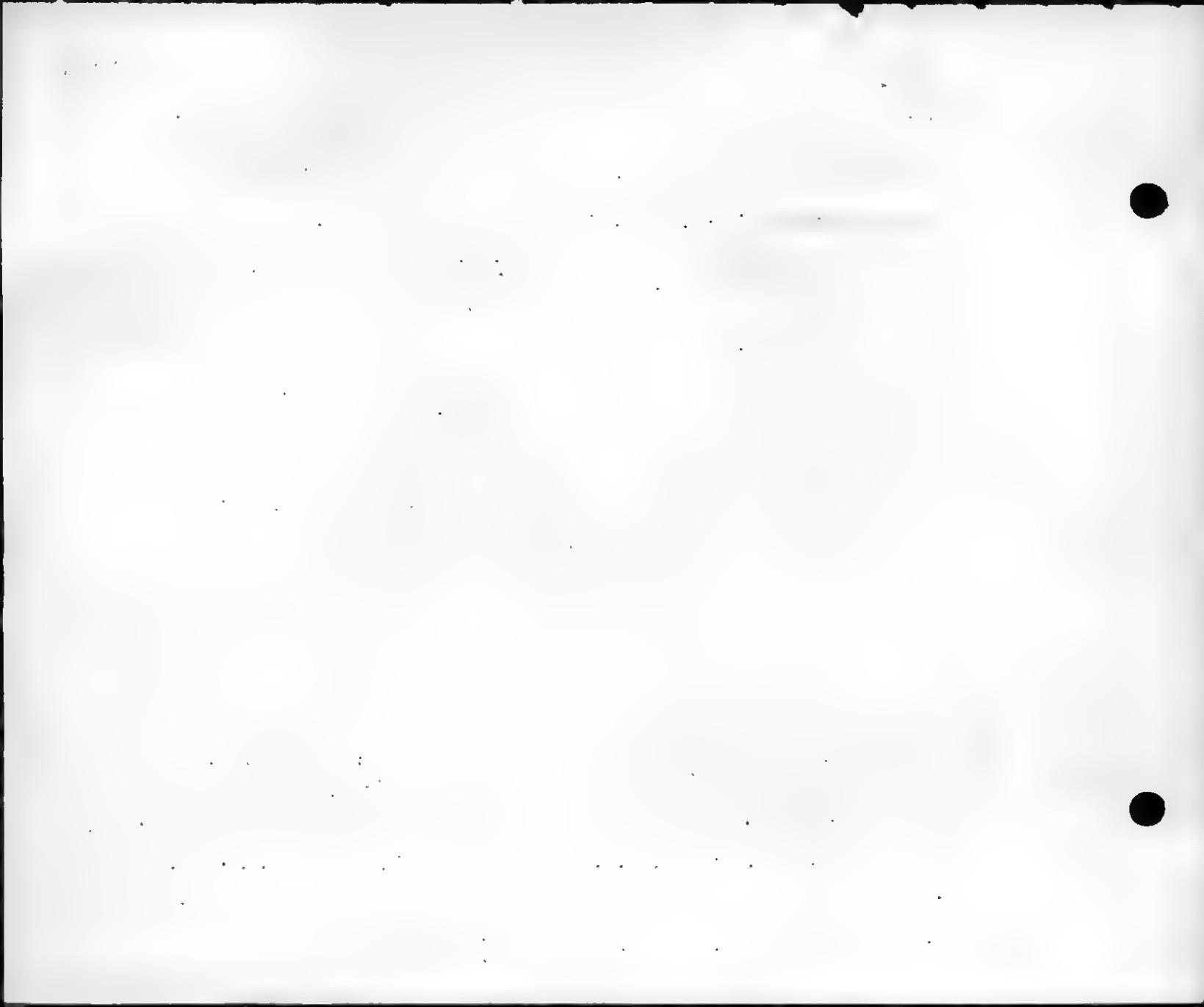
CERTIFICATE OF DEATH

06216

Item 8 Form 6313 Rev. 6-65

04309

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1B <b>14 days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Heights</b>			
3. NAME OF DECEASED (Type or print) <b>Angelo</b>		First	Middle	Last	4. DATE OF DEATH <b>March 19 1966</b>	Month	Day	Year	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/28/86</b>	9. AGE (in years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - U.S. Post</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Ta.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>George Williams</b>		14. MOTHER'S MAIDEN NAME <b>Bellis</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William E. Williams - Son</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Embolism</b> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiac Disease</b> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>AM</b> (this hospital) attended the deceased from <b>March 5, 1966</b> , to <b>March 19, 1966</b> , that <b>AM</b> (we) last saw the deceased alive on <b>March 19, 1966</b> , and that death occurred at <b>6:35 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>March 19, 1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince George's Genl. Hosp., Cheverly Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-23-66</b>		23b. DATE THEREOF <b>3-23-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Flat Harmony</b>		23d. LOCATION (City, town or county) <b>Hagerstown, MD</b>		(State)	
24. FUNERAL DIRECTOR <b>45 Washington &amp; Sons</b>		ADDRESS <b>4925 Main St.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then have removed carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

1 (M)

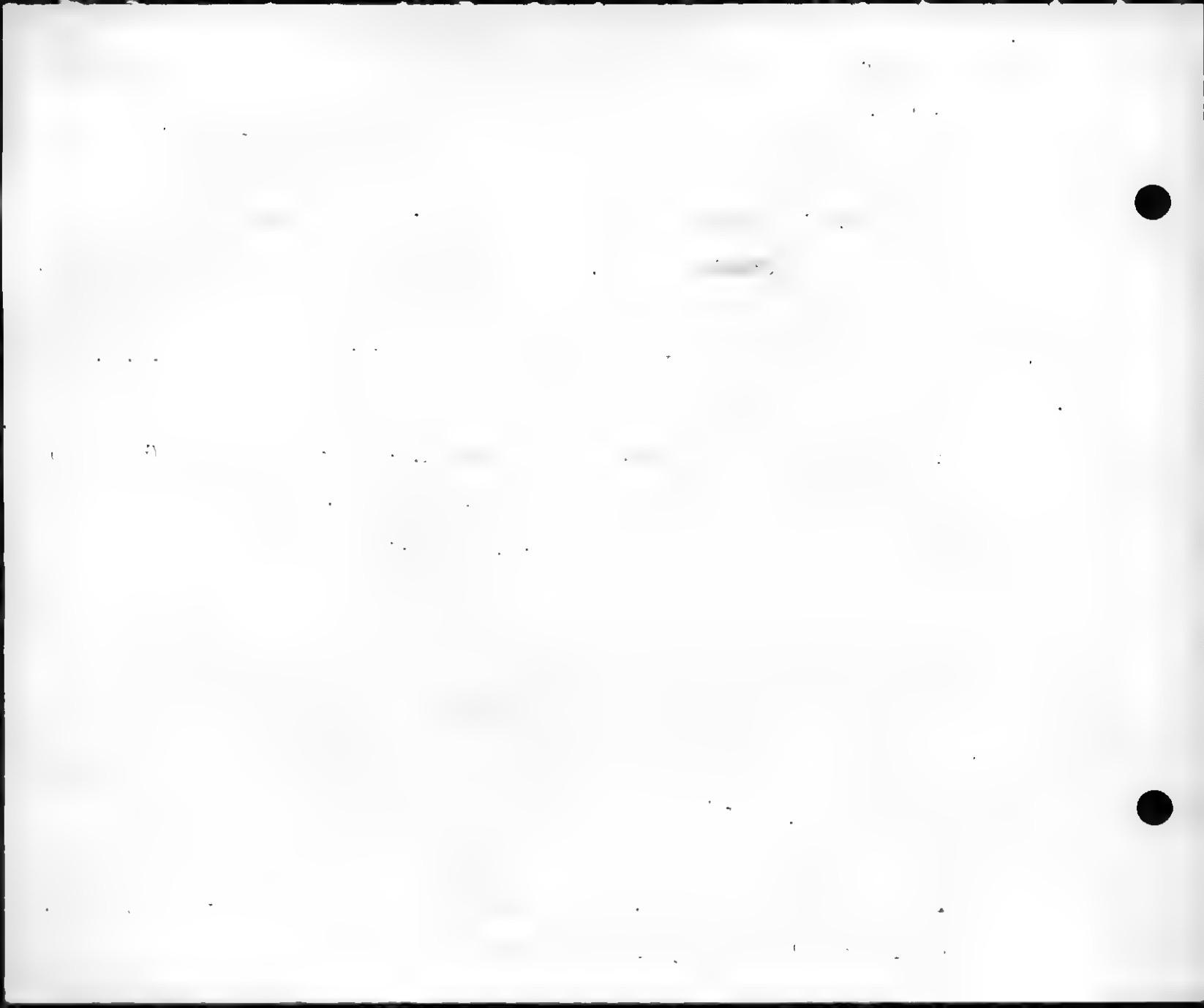
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04315

CERTIFICATE OF DEATH

04310

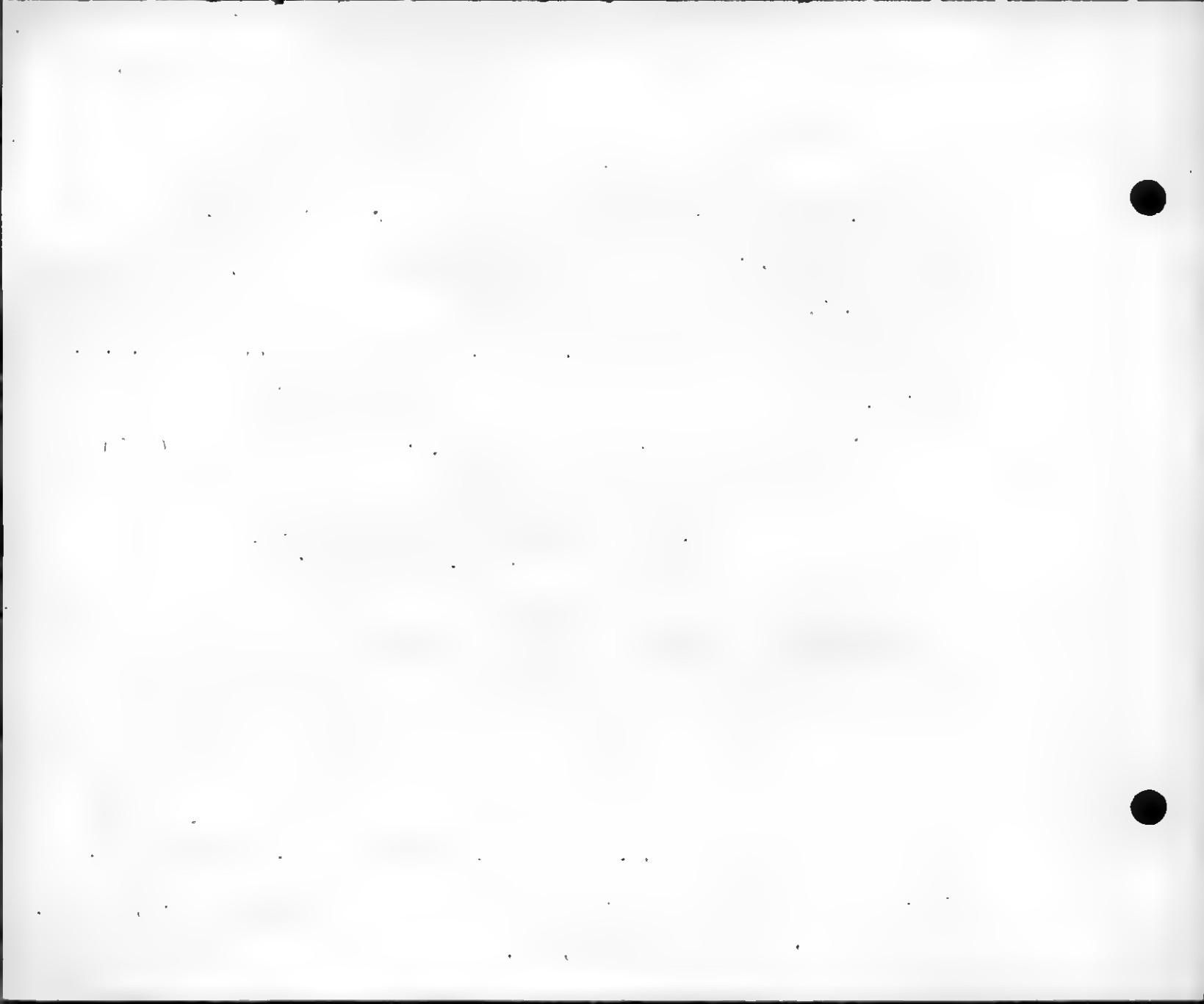
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1B <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>9427 Worrell Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Jennie</b>	Middle <b>P.</b>	Last <b>Wilson</b>
4. DATE OF DEATH Month <b>March</b>	Day <b>10</b>	Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-2-05</b>
9. AGE (in years last birthday) <b>61 yrs.</b>	10. IF UNDER 1 YEAR Months <b>61</b>	11. IF UNDER 24 HRS. Days <b>hrs.</b>	12. IF UNDER 24 HRS. Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Iaase Whitefield Perkins</b>	14. MOTHER'S MAIDEN NAME <b>Rosa Bell Cole</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>William E. Wilson Same as #2 (husband)</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1 Bilateral emphysema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2: Bronchopneumonia</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>5-11</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <i>June 1, 1965, to March 10, 1965</i> , that (I) (we) last saw the deceased alive on <i>March 10, 1965</i> , and that death occurred at <b>10:05</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>3/11/65</b>	
22a. SIGNATURE <i>Francis Mendel</i>		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> am MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>1410-74<sup>th</sup> Ave Hyattsville, Md.</i>
22c. PHYSICIAN'S NAME (Type) <b>C. LOUIS MENDEL</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3/14/66</b> 23c. NAME OF CEMETERY OR Crematory <b>St. Pauls Lutheran</b> 23d. LOCATION (City, town or county) (State) <b>Jackson Township, Pa.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	25a. REC'D BY REGISTRAR <b>MAR 15 1966</b> 25b. REGISTRAR'S SIGNATURE <i>francis Gasch's Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
Prince George's Maryland				a. STATE b. COUNTY									
Cheverly				Maryland Prince George's									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
William				W		Wilson	March	10	19	66			
5. SEX Male				6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-02	9. AGE (In years last birthday) 63 yrs.	FUNDER 1 YEAR <input type="checkbox"/> FUNDER 24 HRS Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner				10b. KIND OF BUSINESS OR INDUSTRY Printing Co.				11. BIRTHPLACE (County & State, or foreign country) Prince George Co., Md				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph P. Wilson				14. MOTHER'S MAIDEN NAME Georgie Wallis									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 577 10 3582				17. INFORMANT Ethel C. Wilson Same as #2 (wife)				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion, anterior descending Coronary Arteriosclerotic Heart Disease (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Aneurysm of the Abdominal Aorta													
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Riverdale, Md.		(County) Baltimore Co.		(State) Md.	
21. I certify that (I) (The physician) attended the deceased from 3-8-66 to 3-10-66, that (I) last saw the deceased alive on 3-9-66 and that death occurred at 2:41 P.M. from the causes and on the date stated above.													
22a. SIGNATURE <i>John Kehoe</i>				22b. DATE SIGNED 3/10/66									
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.				22d. ADDRESS 6300 Riverdale Rd. Riverdale, Md.									
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial				23b. DATE THEREOF 3/12/66		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel				23d. LOCATION (City, town or county) Upper Marlboro, Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Md.									
25a. REC'D BY REGISTRAR M.D. 11 1966				25b. REGISTRAR'S SIGNATURE <i>Merle J. Judge</i>									



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04317

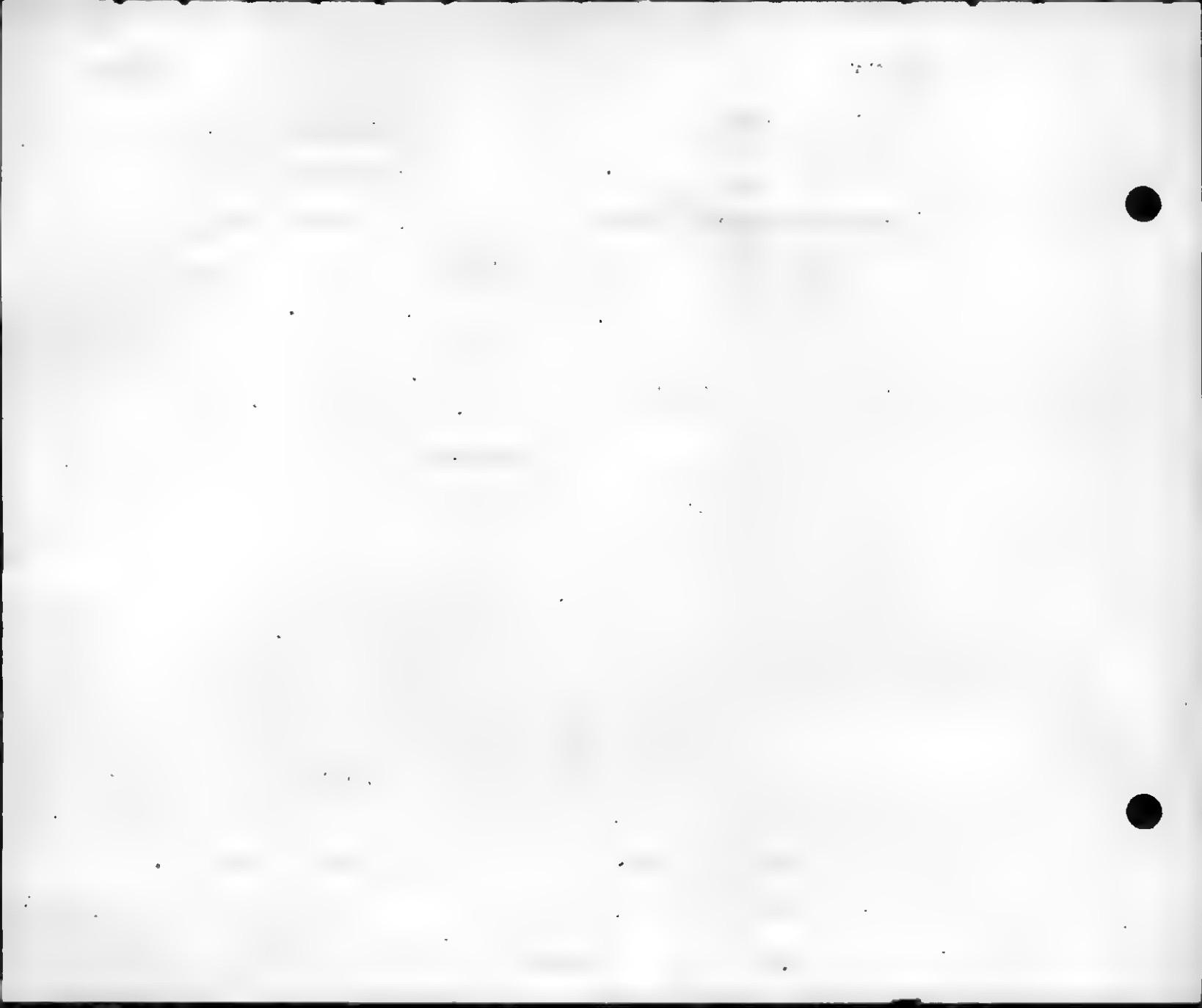
## CERTIFICATE OF DEATH

04312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

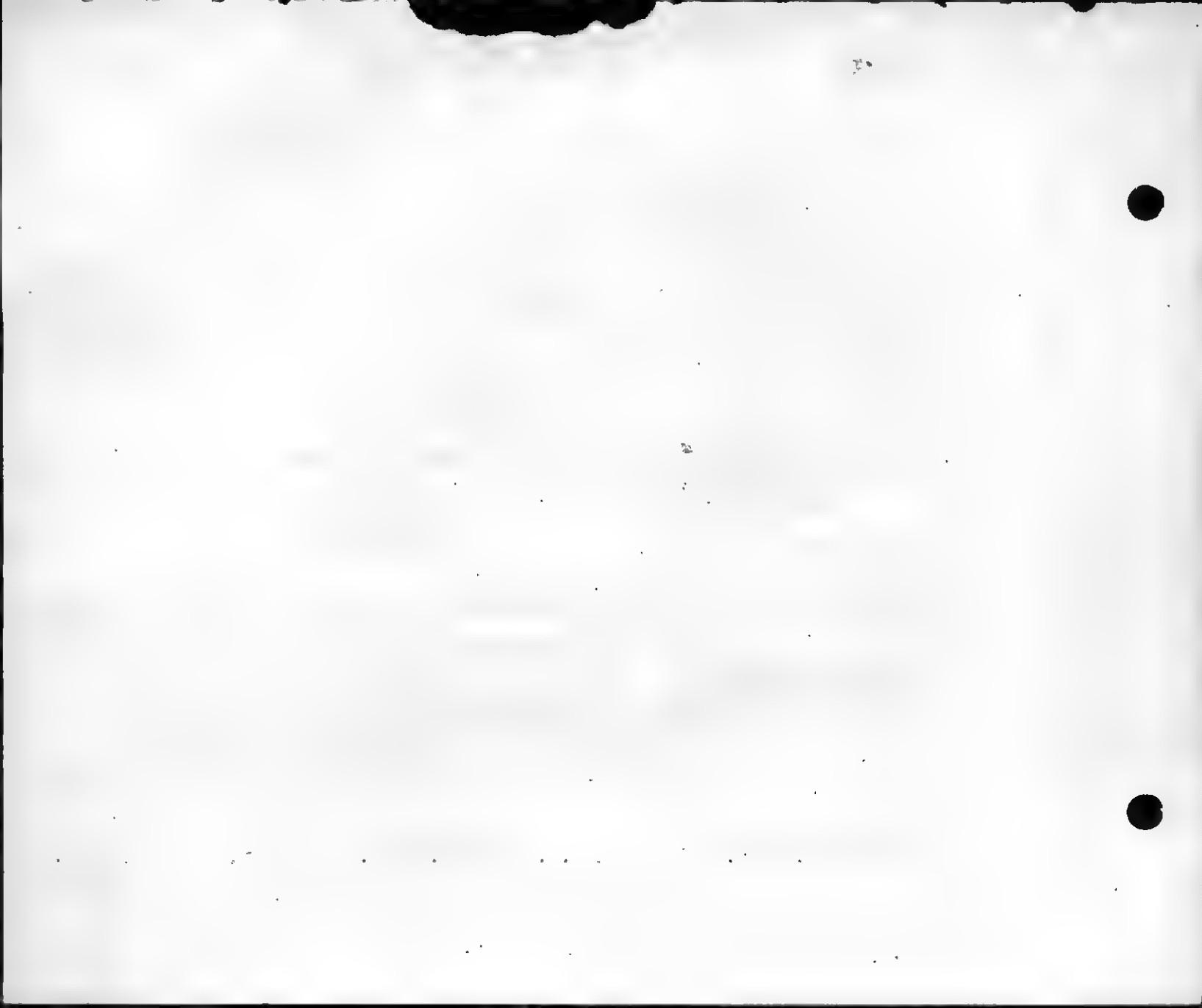
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Palmer Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>						d. STREET ADDRESS <b>7613 Oxonman Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roy J. Windsor</b>		First <b>Roy</b>		Middle <b>J.</b>		Last <b>Windsor</b>		4. DATE OF DEATH Month <b>March</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>11 Nov., 1893</b>		9. AGE (In years last birthday) <b>77 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Windsor</b>				14. MOTHER'S MATURE NAME <b>Neiva Jensen</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>George Windsor Same as 12</b>				INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b> DUE TO (b) <b>Chronic Bronchitis + Emphysema</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary Atherosclerosis + Infarction</b>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>3-24, 1966, to 3-29, 1966</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
<b>19</b>									
21. I certify that (I) (this hospital) attended the deceased from <b>3-24, 1966</b> , to <b>3-29, 1966</b> , that (I) (We) last saw the deceased alive on <b>3-29, 1966</b> , and that death occurred at <b>3:00 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Edwin S. Jensen</b>		22b. DATE SIGNED <b>3/29/1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>Edwin S. Jensen</b>		22d. ADDRESS <b>Prince George Hospital</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/31/1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Mary's</b>		23d. LOCATION (CITY, TOWN OR COUNTY) <b>Washington, Maryland</b>		(State)	
24. FUNERAL DIRECTOR <b>Robert A. Mettingly</b>		ADDRESS <b>1817 1/2 Park</b>		25a. REC'D BY REGISTRAR <b>MAR 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that this death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Prince George</b> MARYLAND					b. STATE <b>MARYLAND</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>C.</b>	Last <b>Weintraub</b>	4. DATE OF DEATH		Month <b>APR</b>	Day <b>4</b>	Year <b>1966</b>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<b>Housewife</b>		<b>Own Home</b>		<b>LAUREL, P.G., Md.</b>			<b>U.S.A.</b>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
<b>GEORGE W. ALCORN</b>		<b>BERTHA Hobbs</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<b>NO</b>		<b>579-32-6010</b>		<b>Wilbert E Wires</b>		<b>13 P Ridge Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: (a) Advanced cirrhosis and Hepatic Failure									
IMMEDIATE CAUSE (a) DUE TO (b) (c) Bilateral marked pulmonary edema, Congestion.									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from <b>3-16-66</b> , 19 <b>66</b> , to <b>3-27-66</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>3-27-66</b> , 19 <b>66</b> , and that death occurred at <b>:M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>William C. Weintraub</i>									
22b. DATE SIGNED <b>3/28/66</b>									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		23d. LOCATION (City, town or county) (State)					
<b>William C. Weintraub, M.D.</b>		<b>Prof. Bldg. Centerway, Greenbelt, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)			
<b>Burial</b>		<b>3-30-66</b>		<b>Arlington National</b>		<b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<b>DeWitt Danedan Laurel, Md.</b>				<b>APR 4 1966</b>		<b>Charles Judge</b>			
DATE									



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04314

04314

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Suitland

c. LENGTH OF STAY IN 1b

5 Days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suitland Nursing Home, Inc.

3. NAME OF DECEASED  
(Type or print)

First Middle

Sarah Frances

Last

Wise

4. DATE OF DEATH

March 31,

Month

Day

19 66

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

10/20/1877

9. AGE (In years last birthday)

88 yrs.

10. USUOER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Mississippi

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Stephen Turner

14. MOTHER'S MAIDEN NAME

Martha Lombeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

4703 Bromley Ave.  
Mrs. W. Bill Powell Suitland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1200 DUE TO

Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c) DUE TO

INTERVAL BETWEEN ONSET AND DEATH  
2 years

Generalized arteriosclerosis (year)

arteriosclerosis heart disease (5 years)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERRYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m.

While at work  Not While at work

p.m. 19

at work  at work

21. I certify that (I) this hospital attended the deceased from

7-7-52 to 3-31-66, that (I) last

saw the deceased alive on 3-29-66, and that death occurred at 4:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE

David Gordon, M.D.

22b. DATE SIGNED

3/31/66

22c. PHYSICIAN'S NAME (Type)

David Gordon, M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

5731

- 23rd Phwy., Hillcrest Hts.

Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

4-4-66

23c. NAME OF CEMETERY OR CREMATORIUM

Odd Fellows Rest

23d. LOCATION (City, town or county)

Aberdeen, Miss.

23b. DATE THEREOF

4-4-66

ADDRESS

Robert E. Wilhelm

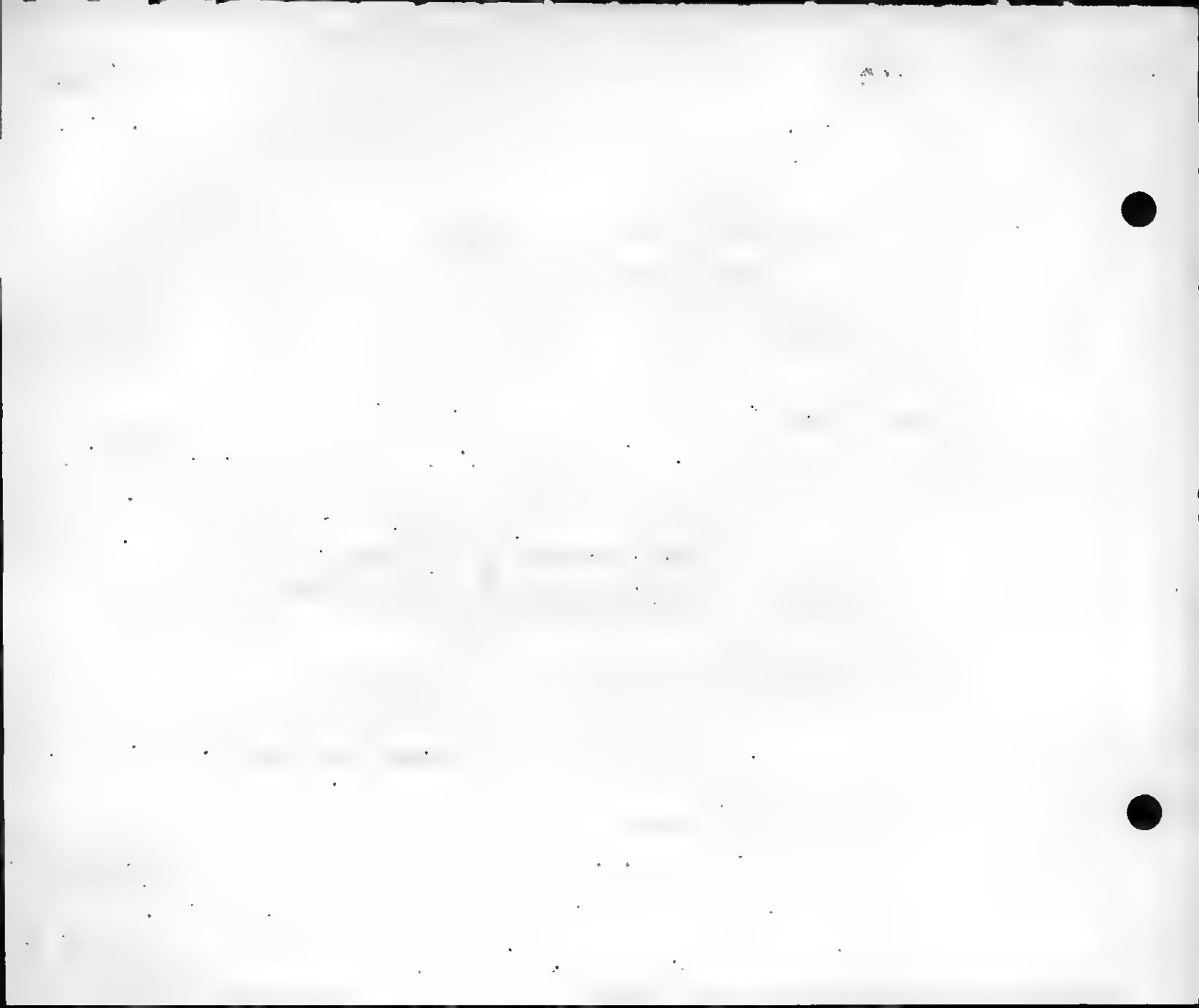
4303 Suitland Rd.

Suitland, Md.

25a. REC'D BY REGISTRAR

APR 4 1966 Charles Judge

DATE



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be retained within 24 hours after death.

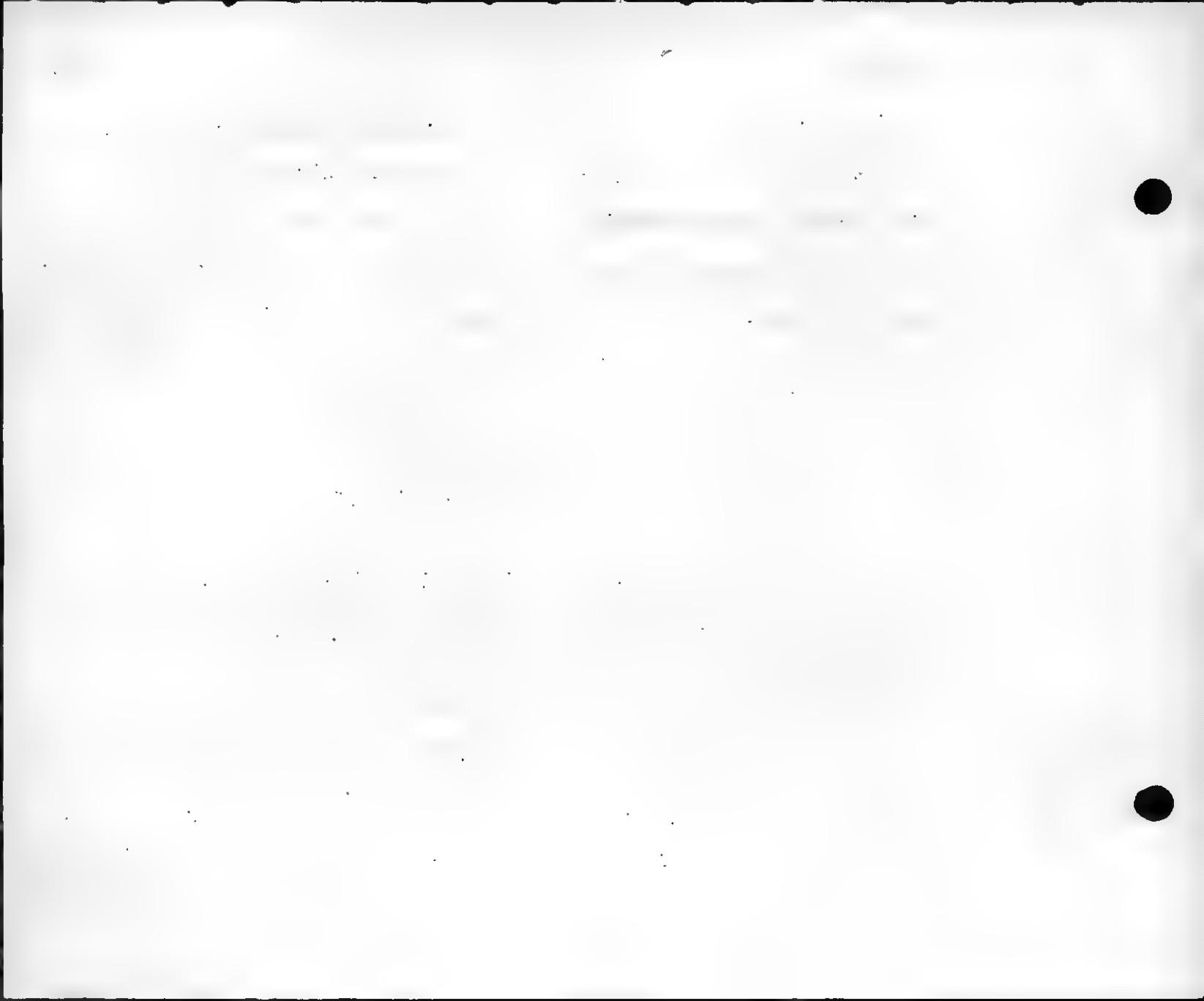
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

06220 04315

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>2514 Lyons Street</b>				
3. NAME OF DECEASED (Type or print)	First <b>Margaret</b>	Middle <b>H.</b>	Last <b>Wolfe</b>			
4. DATE OF DEATH <b>March 11 1966</b>	Month <b>March</b>	Day <b>11</b>	Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-12-06</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) <b>59 yrs.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>Edward Jackson Harris</b>	14. MOTHER'S MAIDEN NAME <b>Susan Myers</b>	Address <b>Same as #2</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Robert H. Wolfe</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <b>arteriosclerotic heart disease</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>+</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cardiac cataracts, diabetes, hypertension, pulmonary edema.</b>						
19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>injury</b>	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-11-66</b> , 19, to <b>3-11-66</b> , 19, that (II) (we) last saw the deceased alive on <b>3-11-66</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.	22a. SIGNATURE <b>Don B Cameron</b>	22b. DATE SIGNED <b>3-12-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Don B. CAMERON</b>	ATTENDING M.D. <b>X</b>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>8503 PERRY ST</b>	23d. LOCATION (CITY, TOWN OR COUNTY) (STATE) <b>Suitland Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/15/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	25a. REC'D BY REGISTRAR <b>J. Wm. Lees Sons</b>	25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	ADDRESS <b>300 4th St. NE Wash., DC</b>	
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons</b>	DATE					



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. LENGTH OF STAY IN 1b <i>30 years</i>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>9508-Rhode Island Ave.</i>		d. STREET ADDRESS <i>9508-Rhode Island</i>	
3. NAME OF DECEASED (Type or print) <i>MARY H. Wood</i>		4. DATE OF DEATH Month Day Year <i>3 - 14 - 1966</i>	
5. SEX <i>Female</i>		6. COLOR DR RAGE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>7-25-81</i>		9. AGE (In years last birthday) <i>84 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>S.S.A.</i>	
13. FATHER'S NAME <i>William A. Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Annie M. Fenwick</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>William F. Wood Same as #2</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchitis pneumonia</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Diabetes Mellitus</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Severe psychosis - hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/9</i> , 19 <i>37</i> , to <i>3/14</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3/14</i> , 19 <i>66</i> and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>J. M. Warren</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>J. M. WARREN</i>		22d. ADDRESS <i>305-Prince George St. Laurel Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-17-66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Seaford Maryland</i>	
24. FUNERAL DIRECTOR <i>W.W. Chambers Jr. 517-11th St. S.E.</i>		25a. REC'D BY REGISTRAR <i>MAR 21 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

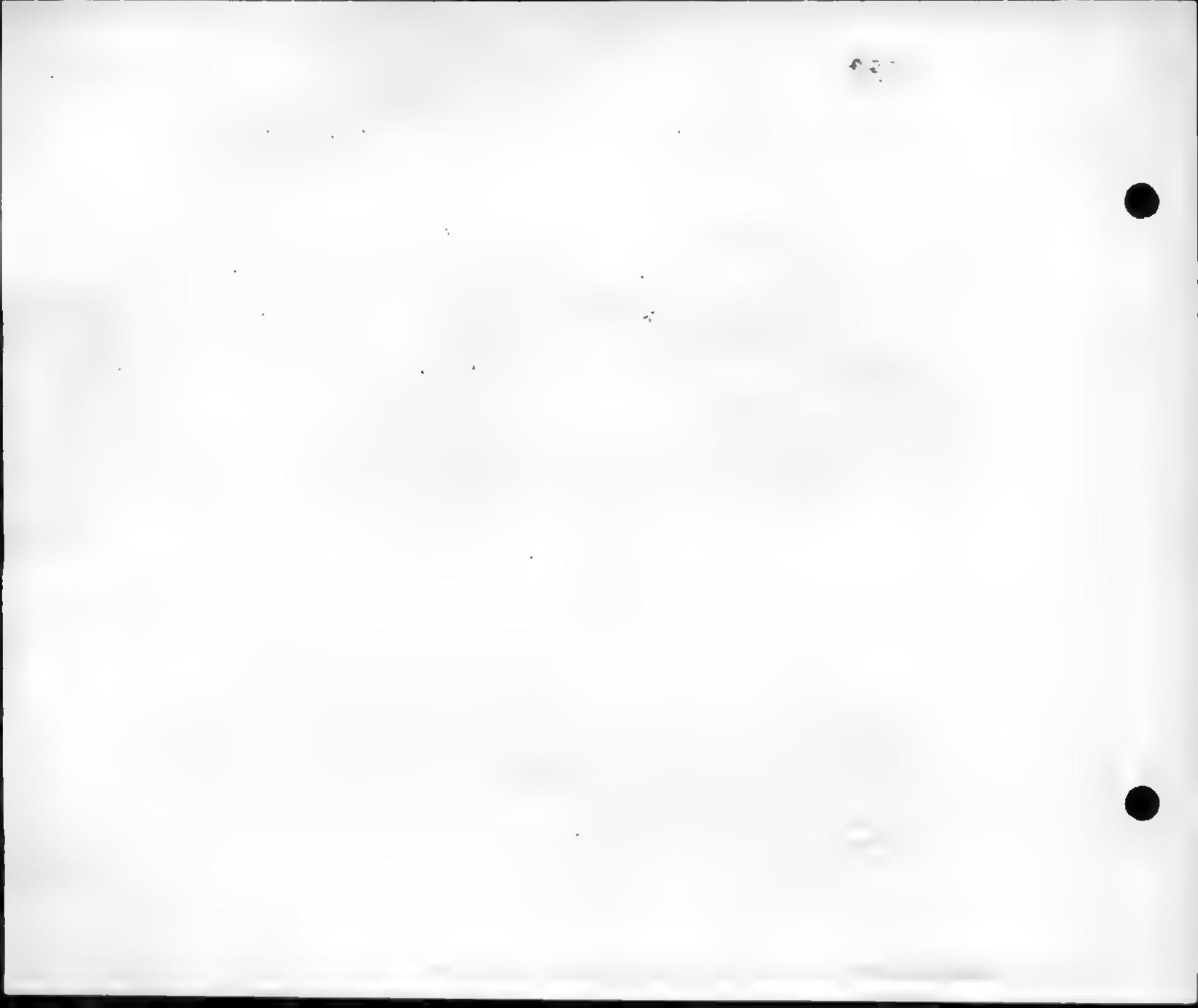
04322

## CERTIFICATE OF DEATH

04317

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.****10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Prince Georges MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Lankham		444 MT. RAINIER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Magnolia Gardens Nursing Home		4441 RAINIER AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Ida		May	Wright
4. DATE OF DEATH		Month	Day Year
March 28		1966	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH
f.	w		Apr. 8, 1882
9. AGE (In years lost birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
83 yrs.		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
HOUSEWIFE		AT HOME	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Wash. D.C.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
GEORGE W. PERKINS		UNK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
No		UNK	
17. INFORMANT		Address 8130 Wisc. Ave BETHESDA, MD.	
NORMAN E. WRIGHT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		coronary atherosclerosis	
DUE TO		3 days	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b)		myocardial infarction	
DUE TO		3 days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____; that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 8 P.M. from causes and on the date stated above.		22b. DATE SIGNED 3-29-66	
22c. SIGNATURE DR LEON R. LEVITSKY		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 3408 R.I. AVE RAINIER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-31-66	
23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) BLADENSBURG MD.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO.		25a. ADDRESS RIVERDALE, MD.	
		25b. REC'D BY REGISTRAR APR 4 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04323

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04318

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b>		c. LENGTH OF STAY IN 1b <b>6 Mos.</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Pr. Geo.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6331 Marlboro Pike</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JERRY</b>		First <b>V.</b>	Middle <b>ZBANEK</b>	Last <b></b>	4. DATE OF DEATH <b>March 18 19 66</b>	Month <b>March</b>	Day <b>18</b>	Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Oct 1888</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS. <input type="checkbox"/>	Months <b>77</b>	Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taylor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13. FATHER'S NAME <b>Jerry Zbanek</b>		14. MOTHER'S MAIDEN NAME <b>Magdalena ??</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577 01 3597</b>		17. INFORMANT <b>Otti J Zbanek</b>		Address <b>Same as # 2 (Wife)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>Due to (b) Cerebral arteriosclerosis years</b> <b>Due to (c) Generalized arteriosclerosis years</b>											
INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>none</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Dayton O'Watkin</b>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>DAYTON O'WATKIN</b>		22. DATE SIGNED <b>3 - 18 - 66</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/21/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Washington National Cem.</b>		23d. LOCATION (City, town or county) <b>Suitland</b>		(State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		b. COUNTY <b>PRINCE GEORGE'S</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGE'S GEN HOSPITAL</b>		d. STREET ADDRESS <b>5809 DEWEY ST.</b>	
3. NAME OF DECEASED (Type or print) <b>FEMALE AGNES</b>		First <b>ZIMMERMAN</b>	Middle <b>ZIMMERMAN</b>
4. DATE OF DEATH <b>3 Oct 1884</b>		Last <b>MAR</b>	Month <b>6</b>
5. SEX <b>CAUCASIAN</b>		6. COLOR OR RACE WOMANED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>81 yrs.</b>		9. AGE (In years last birthday) <b>81 yrs.</b>	10. FUNDER 1 YEAR Months <b>1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>HENRY ZIMMERMAN</b>	
14. MOTHER'S MAIDEN NAME <b>FANNIE SIMMONS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ELNORA B. DAY</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thromb</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>4200</b>		DUE TO <b>Arteriosclerotic heart disease</b>	
DUE TO <b></b>		DUE TO <b></b>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia</b>			
20a. ACCIDENT WAS UNDERTHLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>
20f. (City or town) <b></b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-11</b> , 19 <b>66</b> , to <b>3-1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-4-66</b> 19 <b>66</b> , and that death occurred at <b>51 CM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. P. Clum</b>		22b. DATE SIGNED <b>3-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN P. CLUM.</b>		ATTENDING M.D. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL/CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9 MAR 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>MT. OLIVET CEM</b>
23d. LOCATION (City, town or county) <b>WASHINGTON, D.C.</b>		(State)	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, MD</b>		ADDRESS <b></b>	25a. REC'D BY REGISTRAR <b>MAR 9 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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